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**THE MEANING-CENTERED ANOREXIC BODY: A HUMAN
RIGHTS-BASED APPROACH TO INVOLUNTARY
TREATMENT**

by

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A thesis submitted in fulfilment of the requirements
for the degree of
Doctor of Philosophy

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Declaration

I certify that the thesis I have presented for examination for the PhD degree of the Birkbeck, University of London is solely my own work other than where I have clearly indicated the works of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

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ABSTRACT

This is a meaning centred study of the anorexic body. Its objective is to establish that anorexia nervosa is not exclusively a psychiatric condition and present a new enforceable alternative approach to the current “doctor-knows-best” treatment method which predominantly reiterates labelling and stereotyping in mental health practice. Contextual clinical narratives pose strong critical arguments reiterating that anorexia nervosa is solely due to mental illness which results to diminished autonomy, therefore, unconsented clinical interventions are within the rights of medical practitioners and not a violation of the person’s rights. This research shows that the clinical preference of disengaging with the subjective meaning underlying self-starvation reinforces paternalistic intervention of medical practitioners to the detriment of asserting rights.

Thus, this work is concerned with how to reconceptualise anorexia by meaningfully engaging and managing the anorexic body without using involuntary, coercive and forceful methods, thereby preserving their autonomous rights, best interests and subjective will. Although the current traditional approach under mental health laws is shown to produce no long-term recovery benefits or outcome for the anorexic body, Section 2 of the 1983 Mental Health Act still preserves the one-dimensional strict approach to the care and management of the anorexic body as they are detained for the treatment of both their physical and mental disorder. Through critical research and empirical work conducted in Nigeria, this thesis sustains the deconstruction of

anorexia nervosa as exclusively a psychiatric disorder and enables the development of a meaning-centred anorexic body highlighting the limitation of the traditional western medical model to acknowledge the significant cultural and social dimensions that overrule anorexia nervosa. This research showed that the meaning-centred anorexic body is acknowledged and valued as a self-determining agent outside the confined spaces of the Mental Health Act, adverse and resistant to the established stereotypical boundaries and impositions of psychology, law and psychiatry.

In examining Articles 3, 5 and 8 of the European Convention on Human Rights (ECHR), this research underpins the meaning-centred approach within a human rights based framework. It therefore establishes that human dignity and autonomous choices are integral and indispensable in creating a balanced code of medical ethics. Through critical analysis and both legal and non-legal considerations, this research identifies the meaningful emergence of a modern anorexic body removed from strict confines of the mental health laws' universal attraction and acknowledgement of the body as a docile object that needs to be institutionally regulated, disciplined, and subjected to punishment. The main contribution of this thesis is in bringing clarity to a very conflicting area by identifying a meaning centred approach to the understanding of anorexia nervosa. A conceptualised spectrum is introduced by distinguishing the meaning-centred anorexic body thereby enhancing the realisation of self-determination. In this regard, this thesis establishes the values of autonomous choices as central to dignifying the anorexics experiences, morals and choices and therefore can possess the much-required capacity to regain and retain bodily control, bodily integrity and autonomy. It is based on this independent setting that a meaningful study of anorexia nervosa can emerge, highlighting the values of individual freedom and the

necessity of a human rights-based approach existing outside the traditionally modelled benevolent paternalism.

INTRODUCTION

The notion that the anorexic body requires involuntary detention and psychiatric evaluation for the treatment of their eating disorder has emerged as one of the most disputed and contentious topics in the field of healthcare. Current research trends highlight the struggle by clinicians to find the appropriate setting for a comprehensive and uniform overview of the multifactorial nature of eating disordered behaviours. Psychological therapy, nutritional intervention and hospitalization are therefore, options utilized for the involuntary treatment of the anorectic.¹ Clinical and legal rhetoric are unclear on whether mentally disordered individuals can refuse involuntary treatment on the grounds of human rights violations. The challenge is to provide sufficient individualised evidence to firstly disconnect anorexia nervosa as solely a mental illness and then dispel the mental health law narrative of exclusively connecting abnormal eating patterns to lack of mental capacity to make medical decisions. Critical analysis of the mental health laws reveals lacunae in bridging the gap between the autonomous actions of persons adjudged to be mentally ill and unconsented treatment enforced by clinicians. With self-starvation solely viewed as a psychiatric condition, it is difficult to find a sustainable balance between what constitutes individualised perspective underlying abnormal eating behaviour and the prevalent medical narrative that reinforces involuntary intervention. Medical responsibility to protect the welfare of disordered individuals therefore extends

¹ National Collaborating Centre for Mental Health (UK). 'Eating Disorders: Core Intervention in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders' 2004 9(6) available at <https://www.ncbi.nlm.nih.gov/books/NBK49301/> [Accessed 3rd April 2018]

beyond offering basic relief for their mental disorder, to providing life-saving therapy. Thus treating the psychiatric condition is important to clinicians hence involuntary intervention is therefore administered readily without due consideration of the values of autonomy and bodily integrity of the individual. Although involuntary psychiatric treatment most times produces negative experiences which do not influence recovery outcomes², the individual's identity as a self-determining agent is still relegated to the background in favour of life-saving interventions. Constant refusal and resistance of medical reasoning behind involuntary treatments by the anorexic is registered as underscoring the abnormal behaviour precipitated by the existing mental disorder regime.

The prevalent paternalistic approach in treating mental disordered individuals reinforces the existing labelling, stigmatizing, discrimination and stereotyping of abnormal behaviours.³ Saya et al argues, "establishing the presence of mental illness is not sufficient ground for imposing involuntary psychiatric treatment".⁴ It is acknowledged that the issues surrounding involuntary treatment "centres on the issues of freedom and self-determination".⁵ Invariably, contextual clinical narratives pose strong critical arguments that mentally disordered individuals have diminished autonomy. For clinicians, it is therefore rational to assert that involuntary treatment cannot violate a mentally disordered person's rights.⁶ Accordingly, when backed by legislation, respect for human rights will not take precedence. Moreover, there is still

² Anna Saya, Chiara Brugoli, Gioia Piazzzi, Daniela Liberto, Gregorio Di Ciaccia, Cinza Nioluand Alberto Siracusano 'Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review' 2019 10(271) *Font Psychiatry* p.20

³ Link G. Bruce, Lawrence H. Yang, Jo. C. Phelan and Pamela Y. Collins, 'Measuring Mental Illness Stigma' 2004 30(3) *Schizophrenia Bulletin* p.511

⁴ Saya et al. *op. cit.*, p.2

⁵ *Ibid*

⁶ Eugene B. Brody, *Biomedical Technology and Human Rights* (Hants, Daltmouth Publishing Company Limited 1993) pp.180-185

the question of the yardstick to determine what is right and the resolution mechanisms to address rights in conflict.⁷ The challenge is to determine the extent to which unconsented treatment is ethically justifiable especially in instances where an individual's right to autonomy and self-determination is not considered as a legally enforceable right. Although it is universally acknowledged that individuals have the right to participate in decision-making regarding their treatment, however, once the individual is categorised as a patient, their autonomous rights are significantly reduced.⁸ The individual, therefore, transitions from a person with rights to a sufferer at the benevolence of the medical system, denied basic dignity and freedoms despite the rationality of their morals and values.⁹

I. Background

Clinical views of the evolving nature of mental health and mental disorder are constantly shaped by psychiatry through diagnosis and prognosis, however, there is also established speculation and assumptions on the cause of mental disorder, which also forms part of the treatment prescription.¹⁰ Psychiatry established anorexia as a mental disorder with “the highest rate of mortality”.¹¹ Although the complexities involved in treating and managing anorexia nervosa are gradually emerging from obscurity to becoming better understood in medicine, psychiatry, and law,¹² there is still established uncertainty around the cause and also the lack of clarity to the large

⁷ Justin Burley, *The Genetic Revolution and Human Rights* (New York, Oxford University Press 1999) p.105.

⁸ *Ibid.*

⁹ Brody, *op. cit.*, pp.180-185.

¹⁰ Anne Rogers and David Pilgrim, *A Sociology of Mental Health and Illness* (Berkshire, Open University Press 2014). p.1.

¹¹ Jane Morris and Sara Twaddle ‘Anorexia Nervosa’ (2007) 334(7599) British Medical Journal p.898.

¹² Arthur H Crisp, ‘Anorexia Nervosa at Normal Body Weight – The Abnormal Normal Weight Control Syndrome’ (1981) 11(3) International Journal of Psychiatry p.204.

cultural component of the diagnosis. The practice of equating forms of abnormal behaviour to mental illness decreased between the seventeenth and twentieth century due to the emergence of medical explanations and psychiatric solutions to disordered behaviours. Analysing competing explanations and interpreting observational concepts about anorexia nervosa is, on its own, an intellectual ‘tour de force’ and will always raise conflicting views. At no point in this research will the need arise to construct a convincing argument to downplay the severity of any form or variation of mental illness or psychiatric disorder. Treating or managing self-starving persons or individuals with variety of food restrictive patterns is, therefore, by no means a straightforward process and, in most cases, involves multiple approaches from diverse fields. There is, however, no misconception that extreme forms of food restriction can develop into mental illness with severe, relentless consequences,¹³ and can invariably result in very significant medical impairment, disability, and even death.¹⁴ It, therefore, follows that no matter how liberal a diagnosis may appear, paternalistic intervention is immediately initiated to impose involuntary treatments to manage the illness and understandably aid physical recovery. Preliminary research reveals accounts of unconventional and controversial methods of treating persons diagnosed with anorexia nervosa with little or no consideration of the broader spectrum of this condition. Saya et al notes that individuals treated involuntarily feel disempowered, loss of self-esteem and autonomy and make a plea for the acknowledgement of their dignity and respect.¹⁵ Forms of anorexia developed with consciousness and meaning outside the confines of the Mental Health Act 1983 has never been addressed or understood in this field of study. A proper analysis shows patterns where the

¹³ *NHS Trust v L* [2012] EWHC 2741 (COP) para.1.

¹⁴ Hilde Bruch, ‘Anorexia Nervosa: Therapy and Theory’ (1982) 139 (12) *The American Journal of Psychiatry* p.1531.

¹⁵ Saya et al. *op. cit*, p.19

intervention of medical practitioners supersedes the legal rule and doctrine of obtaining consent before any medical treatment. It is safe to say that in situations of psychiatric diagnosed mental disorder, human rights are second-tiered, whereas paternalistic considerations play a more dominant role in how clinicians decide on the extent and type of compulsory treatment methods suitable.¹⁶

Gremillion considered the consensus approach of clinicians to anorexia as carefully coordinated to not only engineer weight gain but as active participants in the remodelling of their bodies outside defined choices.¹⁷ In resisting the reshaping or involuntary management of their bodies, there is also an acknowledged refusal to accept the alteration of their cultural ideals, bodily experiences and pathological and pathological behaviour.¹⁸ It has become evident that priority is given to the physical recovery of the patient rather than their choice to live as they please. Force-feeding a person is regarded as a form of involuntary treatment,¹⁹ and as such is contestable.²⁰ In retrospect, force-feeding or detaining someone for treatment against their will can give rise to both criminal and civil liabilities.²¹ It is fair to establish that the complexity of this disorder places anorexia nervosa sufferers at the lower end of

¹⁶ Stephen W. Touyz and Terry Carney, 'Compulsory (Involuntary) Treatment for Anorexia Nervosa' (2010) Sydney Law School Legal Studies Research Paper No (10/07) available at [http://www.researchgate.net/publication/228134167_Compulsory_\(Involuntary\)_Treatment_for_Anorexia_Nervosa](http://www.researchgate.net/publication/228134167_Compulsory_(Involuntary)_Treatment_for_Anorexia_Nervosa) [accessed 15th May 2019].

¹⁷ Helen Gremillion, *Feeding Anorexia - Gender and Power at a Treatment Center* (North Carolina, Duke University Press 2003) p.44.

¹⁸ *Ibid.*

¹⁹ Simona Giordano, *Conceptual and Ethical Issues in the Treatment of Anorexia Nervosa and Bulimia Nervosa* (1st edn. Oxford, Clarendon Press 2005). p. 180.

²⁰ Rosalyn Griffiths and Janice Russell, 'Compulsory Treatment of Anorexia of Anorexia Nervosa Patients' in Walter Vandereycken, Pierre J.V Beumont (eds.), *Treating Eating Disorders: Ethical, Legal and Personal Issues* (London, Athlone Press 1998) p.178.

²¹ Eike-Henner Kluge, 'The Ethics of Force Feeding in Anorexia Nervosa: a Response to Hebert and Weingarten' (1991) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1335318/> [accessed 15th May. 2019].

vulnerability, thus requiring greater rights protection under the law.²² Another critic of involuntary treatment relates to the mode of conducting day-to-day activities of these patients while institutionalised. The everyday routine of living an institutionalised life involves involuntary regimented treatment and eating practices, embedded in disciplinary, coercive, regimented, and controlling routine tantamount to inhumane and degrading treatment. Saya et al points out that “the European Convention on Human Rights (ECHR) provides that forced hospitalization should remain in the guaranteed context of article 3 which prohibits any inhuman and degrading treatment”²³ Subjecting anyone to such rituals not only infringes on their freedom, liberty, and free will, but also encroaches on their self-image and self-identity as entrenched under Articles 3, 5, and 8 of the ECHR.²⁴

II. Aims and Objectives

The complex interpretations of eating disorders are often lost in the contemporary clinical settings,²⁵ as the lines between psychiatric and physical illness have remained blurred.²⁶ Doncu points out that “psychiatric diagnosis is itself a game of measuring power and complexity” and there is rarely a demarcation between medical intervention aimed at restoring functioning and balancing out capacities that are already formed.²⁷ *Norfolk & Norwich Healthcare (NHS) Trust v W* reveals a departure from the strict confines of the Mental Health Act criteria for only administering

²² Elizabeth Wicks, ‘The Right to Refuse Medical Treatment under the European Convention on Human Rights (2001) 9(1) Medical Law Review pp. 17–40.

²² *Ibid.*

²³ Saya et al., *op. cit.* p.2

²⁴ European Convention on Human Rights available at http://www.echr.coe.int/Documents/Convention_ENG.pdf [accessed 5th January 2019].

²⁵ Su Holmes, Sarah Drake, Kelsey Odgers and Jon Wilson, ‘Feminist Approaches to Anorexia Nervosa: A Qualitative Study of a Treatment Group’ (2017) 5(36) *Journal of Eating Disorders* p.4.

²⁶ Roxana Elena Doncu, ‘Feminist Theories of Subjectivity: Judith Butler and Julia Kristeva’ (2017) 10 *Journal of Romanian Literary Studies* pp.332-336.

²⁷ *Ibid.*

involuntary treatment to individuals with mental disorders.²⁸ The inherent powers of the court to authorise the use of reasonable force and involuntary detention was extended to individuals not suffering from mental disorder.²⁹ The courts decision authorising involuntary treatment was weighed on the consideration of the ability of W to accept the medical decision and refusal of medical treatment was regarded as inability to comprehend and retain information.³⁰ It was therefore established that individuals who do not possess any form of mental disorder can still be adjudged to lack capacity and are incapable of furnishing their full consent in obtaining medical treatment and therefore can be involuntarily treated without their consent. Invariably, the same approach was also administered in *Rochdale Healthcare (NHS Trust v C)* where involuntary treatment was authorised although the individual "...was fully competent mentally and capable of comprehending and retaining information about the proposed treatment."³¹

Foucault recognised the ability of the body to resist repression and constriction by authoritative powers.³² Institutions, such as hospitals, therefore skilfully serve as agents of manipulation and micromanaging of how the body operates. According to Foucault, "the body had become the object of such imperious and pressing investments; in every society, the body was in the grip of stringent powers which imposed on it constraints, prohibitions or obligations".³³ Critical analysis of the involuntary treatment of the anorexic body in the context of their human rights is

²⁸ [1996] 7 WLUK 38.

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ *Rochdale Healthcare NHS Trust v C* [1996] 7 WLUK 40.

³² Ladelle McWhorter, 'Culture or Nature? The Function of the Term "Body" in the Work of Michel Foucault' (1989) 86(11) Eighty Sixth Annual Meeting American Philosophical Association, pp.608-614.

³³ Michel Foucault, *Discipline and Punish: the Birth of the Prison* (New York, Vintage Books 1995) p.136.

imperative,³⁴ by securing a sound grounding in the theoretical foundations of human rights as entrenched under the ECHR, which is incorporated into English law by the Human Rights Act 1998 (HRA). In other words, by examining the application of involuntary treatments on the anorexic body, the aim is to establish a rights-based standpoint as well as explore the fundamental limitations to asserting their rights. The author reviews the human rights-based approach that positions the protection, respect, and fulfilment of the decisions and choices of an individual as central in all decision-making processes.

Saya *et al* insists “there is much to do in psychiatric field to ensure care, dignity and rights for patients”.³⁵ The overall concern of this thesis is to provide a simple meaningful understanding of anorexia nervosa; with specific focus on whether involuntary treatments are in the best interest of the anorexic body and the human rights implications.³⁶ The focus would be to the interpretation of these rights under the European Convention on Human Rights with particular reference to Article 3 (prohibition of inhuman or degrading treatment) and Article 5 (right to liberty and security) and Article 8 (respect for private and personal life). Coercive involuntary treatment of the meaning-centred anorexic body sets the framework to explore the human rights approach under the ECHR.³⁷ In addition to identifying the procedures for the anorexic body to make human rights claims and ascertain against whom such claim can be made, it is imperative to analyse case law especially previous court decisions which do not reflect the best interests of the patients, as they exclude their

³⁴ Jill Marshall, *Personal Freedom through Human Rights Law? Autonomy, Identity and Integrity under the European Convention on Human Rights* (Netherlands, Martinus Nijhoff Publishers 2008) pp. 13–14.

³⁵ Saya, *et al.*, *op. cit.* p.20

³⁶ *Ibid.*

³⁷ Jill Marshall, ‘A Right to Personal Autonomy at the European Court of Human Rights’ (2008) (3) *European Human Rights Law Review* pp. 337–356.

wishes, choices and morals, are analysed.³⁸ The human rights-based approach will engage the concept of best interest during treatment from a liberal and practical stance to include consent, freedom of choice and right to autonomy. By critically engaging the debate of paternalism and emphasising the obvious repercussions of this defence on individual liberties and autonomy of an anorexic patient, attention is drawn to developing comprehensive framework which highlights the best interest and compliments the right to autonomy of the anorexic body.

III. Theoretical Approach

This thesis explores the intersection between law and medicine with focus on the socio cultural, ethical and medical turbulence in the understanding of anorexia nervosa. The core argument in this thesis is that although clinicians acknowledge the multi-dimensional nature of anorexia, there is still sole dependence on involuntary treatments mechanism to achieve weight gain and aid recovery without due consideration to their autonomous choices and values. The current understanding of anorexia nervosa is mainly clinical driven and do not actively engage the versatile and complex nature of anorexia nervosa. Adopting a module that deconstructs anorexia from the regimented classification projected by clinicians would provide the base for acceptance of a more radical approach to the understanding of the multi-dimensional nature of anorexia nervosa. This work therefore, adopts an inter-disciplinary meaning centred and human rights-based approach. The meaning centred approach is drawn from outside law and provides an alternative method of understanding anorexia. Its effectiveness will enable a rethink of the current clinical approach that does not

³⁸ John Coggon, 'Anorexia Nervosa, Best Interests, and the Patient's Human Right to a "Wholesale Overwhelming of her Autonomy": A Local Authority v. E' (2013) 21(0) Medical Law Review pp. 1–13.

include the multifactorial interplay of cultural variations and experiences. It therefore provides the core setting and link between female body perceptions and the explanation for female body liberation movement by identifying the key resources for their meaning centred behavioural adaptations. The human rights based approach underpins the implementation and adaptation of the meaning-centred approach within a rights based setting. The empirical study will seek to explore if anorexia nervosa can be found in non-western cultures where mental health laws do not recognise anorexia nervosa as a psychiatric condition, therefore, individuals whom fall within the physical spectrum offer a meaningful dimension for evaluation. Nigeria highlights the difference in institutionalised way of mental health practice as well as provides a distinct background for generalisation to be made about likely behavioural patterns and categories in analysing non-western bound syndromes. The non-psychiatric dimension provided by Nigeria simplifies and deconstructs anorexia by revealing an independence of mind and thinking not compliant with western established micromanagement.

RESEARCH QUESTIONS

1. What is a meaning-centred anorexic body and can this approach to self-starvation redefine anorexia as not exclusively a psychiatric condition?
2. Are involuntary treatments in the best interests of the anorexic body and can the Mental Health Laws in the UK recognise the autonomous rights of the anorexic body?

3. Can a meaning-centred anorexic body be identified in non-western cultures and is there significance in addressing medical and psychiatric stereotypes and labelling?
4. Are there human rights implications in the enforcement of involuntary treatments on the meaning centred anorexic body under the European Convention on Human Rights (ECHR)?

THESIS STRUCTURE

Chapter 1 provides a background of the thesis by exploring medical-based stereotypical narrative of the anorexic body as representing non-voluntary actions, which presents the justifiable stance for the non-recognition of their autonomous rights to refuse involuntary treatment.

Chapter 2 presents conceptualised analyses of the behavioural models underling the multifactorial realities of the anorexic behavioural substructure. In addressing the difference between the conceptual analysis of disease and illness, a broader theme of individualised assessment of anorexia nervosa as a meaningful disease emerges. Establishing the co-relation between body image discontent and self-satisfaction becomes pronounced in the assertion of bodily integrity and in exercising the rights to refuse treatment. Self-starvation and food refusal therefore become a symbol of resistance to paternalistic body control.

Chapter 3 evaluates the meaning-centred approach in the involuntary treatment of the anorexic body. This chapter seeks to uncover the meaning underscoring individualised experience as a solution to the ethical challenges facing the traditional anorexic body. **Chapter four** critically examines the meaning, values or reasoning underlying self-starvation, divergent and progressive beyond the traditional stereotypical concepts dominating in the field. **Chapter 5** seeks to identify anorexia nervosa in non-western culture and determine the meaning of self-starvation as a culture bound syndrome. Establishing empirical validity of the meaning centred anorexic body would certify the role of starvation as a tool for self-expression and rights fulfilment thereby devaluing the universal stereotype equating the self-starved body as only representing the presence of mental disorder.

Chapter 6 examines the ethical issues in the application of force-feeding as a treatment for mental disorder. The ethical challenges of involuntary intervention are evaluated in the assessment of best interests as complementary to highlighting convention rights to include the values, choices and decisions of the anorexic. **Chapter 7** evaluates the conceptualisation of a meaning centred anorexic body as a bearer of rights by ensuring that their valued choices and experiences within health care are recognised. Further analysis of the idea that human rights considerations should precede involuntary medical intervention by inclusion of individuals as active or sole participants in the decision making process. This chapter establishes the underpinnings for a right-based approach grounded on the inclusion of their instinct values and personhood thereby creating the bases for autonomous choices. **Chapter 8** presents the conclusion, findings and recommendation.

CHAPTER 1

The Bioethics of Anorexia Nervosa

1. Introduction

This chapter engages with the subject matter of the thesis by critically dissecting the scopes and dimensions of anorexia nervosa in mental health practice. This is a key background chapter which is essential for a bioethical analysis of disordered behaviour by expanding the core definitions of self-starvation outside the confined narratives of the Diagnostic and Statistic Manual of Mental Disorders and the Mental Health Act 1983. The chapter starts by providing a thorough overview of the complex dimensions of anorexia nervosa, then the historical development registers the conflicting dimensions presented by both the medical and none medical regimes. The social cultural dimensions of anorexia becomes rather pronounced as the individual progresses from adolescence to adulthood which is reflected in their experiences, values and way of life. The narrow medical definitions of anorexia places emphasis on the visual presentation of the body and the discussions of apparent thinness as equating with the imagery and perception rather than a diminishing mental health. This chapter concludes by establishing that the belief surrounding anorexia only point to the issues of shallowness and superficiality promoted by the prevalent western visual culture.³⁹ Invariably there is judgement and stereotype models of mental

³⁹ Emma Seaber, 'Reading Disorders: Pro Eating Disorder Rhetoric and Anorexia Life –Writing' (2016) 34(2) Literature and Medicine Journal pp.484-508.

disorder under which the medical model engages with anorexia “leaving little room for alternative narratives, thereby marginalizing accounts of anorexia that do not fit this framework”.⁴⁰

1.1 Defining Anorexia Nervosa

In exploring the historical details of anorexia nervosa, Dell’Osso, Abelli, Carpita, Pini, Carellini, Carmassi and Ricca note that anorexia was first recognized in late 1700 and received its current name in 1874.⁴¹ The first impression the medical experts had was on the cause of anorexia nervosa, which was noted because of endocrine disturbance.⁴² Medical narratives also have not given up on the possibility that anorexia is a disorder of the hypothalamus, especially as certain tumours of the hypothalamus lead to lack of interest in food consumption.⁴³ The changing dimensions and interpretations of anorexia were also reflective of the historical evolution of perspectives of self-starvation and the impact it had on various aspects of an individual’s expression of their values, morals and culture. Anorexia Mirabilis in the middle ages was interpreted within aspects of religious beliefs, which equated thinness with spiritual awareness, purity, and holiness. The morals of perfection were intertwined with the condition and continued into the 1800’s where a dimension, which included material beliefs, was established. The beginning of the recognition of self imposed food refusal as having a psychological and psychoanalytic significance (nervous atrophy and hysteria) progressed into the 1900’s. However, conceptualised clinical significance reflecting emerging trends in the understanding of the thresholds

⁴⁰ *Ibid.*

⁴¹ Liliana Dell’Osso, Marianna Abelli, Barbara Carpita, Stefano Pini, Giovanni Castellini, Claudia Carmassi and Valdo Ricca ‘Historical Evolution of the Concept of Anorexia Nervosa and Relationships with Orthorexia Nervosa, Autism, and Obsessive-Compulsive Spectrum’(2016) 12 Dove Press Journal: Neuropsychiatric Diseases and Treatment pp.1653-1654

⁴² *Ibid.*

⁴³ *Ibid.*

of anorexia is a fairly recent development (2000-2015).⁴⁴ Dell’Osso et al also noted that although self-starvation were noted in the context of extreme fasting, the evolution of the meaning of self starvation in the last three centuries has become separated from spiritual connections of religious beliefs as the trends of body image, feminine appeal and ideals of beauty slowly emerge.⁴⁵ The embodiment of the framework of self-starvation began to slowly reflect both cultural and social values and thus to a great length less reflective of clinical connotation. However, in defining modern anorexia many authors have presented descriptions and analysis that conceptualise voluntary fasting practice within medical and psychiatry frameworks.⁴⁶ The orthodox definition of anorexia has for centuries followed the strict understanding furnished by clinicians who characterized eating related behaviours as both a substantial psychiatric and health impairment.⁴⁷

Sarason and Sarason explain that the term anorexia nervosa means nervous loss of appetite; notwithstanding, those suffering from this behavioural disorder have distorted perceptions of their body which leads to the sustained efforts to remain thin through self starvation and excessive exercise.⁴⁸ Anorexic individuals are also naturally susceptible to both physiological and negative feelings of hunger, in addition to being strongly preoccupied with the morbid fear of food.⁴⁹ Eating patterns of anorexics are unusual and disruptive as there is a “refusal to keep body weight at

⁴⁴ *Ibid.*

⁴⁵ *Ibid.* p.1655.

⁴⁶ *Ibid.*

⁴⁷ Liliana Dell’Osso, Marianna Abellii, Barbara Carpita, Stefano Pini, Giovanni Castellini, Claudia Carmassi and Valdo Ricca ‘Historical Evolution of the Concept of Anorexia Nervosa and Relationships with Orthorexia Nervosa, Autism, and Obsessive-Compulsive Spectrum’ (2016) 12 Neuropsychiatric Disease and Treatment p.1651.

⁴⁸ Irwin G. Sarason and Barbara R. Sarason *Abnormal Psychology: The Problem of Maladaptive Behavior* (New Jersey, Prentice Hall 2005). pp. 190.

⁴⁹ *Ibid.*

above 85% of the generally recognized normal level for age and height'.⁵⁰ One would find them discussing and preparing appetizing meals for friends and family members, but often do not partake in eating what they have prepared. It is a common sight watching these anorexics cutting the food they appear to be eating, into small pieces, only to keep moving them about on the plates and refuse to consume them.⁵¹ Sarason and Sarason argue that the overall weight loss of an individual is not enough to solely account for the presence of anorexia nervosa.⁵² Weight loss is simple but not sufficient and there are often other distinguishable conditions for first base diagnoses of a person with anorexia nervosa. There is therefore a remarkable distinction between warning signs for anorexia and factors that explain the underlying meaning of anorexia. First the warning signs are indicated by the feeling of fatness and then the intense fear of becoming fat even when it is clear the individual's body weight must have lowered up to at least 15 percent lesser than the normal level.⁵³ If the individual is still developing, the weight loss must have at least 15 percent lower than what it is expected to be. In females, the frequency of the menstrual cycle must also be taken into consideration. It is indicated that the female's weight loss is so severe that she loses at least three consecutive menstrual cycles.⁵⁴

Anorexia nervosa is described as an obsessive disorder that amounts to self-starvation and controlled feeding.⁵⁵ Taylor explains that the individual embarks on dieting to the point that grossly reduces the body weight below optimum level that can threaten

⁵⁰ *Ibid.* p.191.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.* p.192.

⁵⁴ *Ibid.*

⁵⁵ Shelley E. Taylor, *Health Psychology* (New York, McGraw-Hill Publishers 2014) p.92.

their physical health and may lead to death.⁵⁶ Alloy, et al identify the fear of weight gain as the reasoning behind severe food restriction in individuals identified as anorexic.⁵⁷ Gazzaniga, *et al* also view anorexia nervosa as an eating disorder in which an individual develops an excessive fear of becoming fat, which leads to food refusal and restrictions.⁵⁸ In context, many adolescent girls embrace self-starvation and strive to be thin, but majority of such adolescents fail to meet the clinical criteria of this disorder and only one percent of adolescent girls meet the anorexic body clinical criteria.⁵⁹ The identified criteria include the psychological characteristics that portray the person as having abnormal obsession with food and body as well as an objective measure of thinness.⁶⁰ Gazzaniga, *et al* go on to report the presence of body dysmorphia as most of the identified females who have anorexia continue to see themselves as being fat even though their body has become under-weight by fifteen to twenty-five percent.⁶¹ Gazzaniga, *et al* also identify other warning signs which precipitate the anorexic behaviour as revolving around constant obsession on weight gain or weight loss and in most cases there is an outright denial of body issues fixation from friends and close relatives.⁶² Self-starvation is always short-lived as the physical body weight degenerates to an unimaginable levels and medical professionals intervene to provide treatment in order to prevent death. Even at this stage, difficulties will still arise in enforcing treatment, as the individual would resist treatment despite being severely emaciated.

⁵⁶ *Ibid.*

⁵⁷ Lauren B. Alloy, John H. Riskind and Margaret J. Manos *Abnormal Psychology: Current Perspectives* (Boston, McGraw-Hill Publishers 2005) p.449.

⁵⁸ Michael S. Gazzaniga, Todd F. Heatherton and Diane F. Halpern *Psychological Science* (New York, W.W. Norton 2018). pp.449-450.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ Gazzaniga *et al*, *op. cit.*, p.449-450.

⁶² *Ibid.*

Coon and Mitterer view anorexia nervosa as an active self-starvation, or sustained loss of appetite, which has some psychological origins.⁶³ The anorexic cycle usually begins with what could be regarded as normal dieting, progressing to dominate the individual's life and eventually leading to very serious health problems.⁶⁴ Anorexics make compulsive attempts to lose weight, which causes them not to desire food, however, the lack of food desire does not stop them from feeling physically hungry. However as the body adjusts to self-starvation the individual is able to cope without food for longer periods. In the early stages of food refusal, weight loss is seen as a strong motivation for food refusal. Coon and Mitterer further explain how to recognise anorexia nervosa. One way is to find out if the person is refusing to maintain body weight within the normal range and if the person's body weight is less than the normal; then the person may be anorexic.⁶⁵

The second method is when there is intense fear of becoming fat or gaining weight even when the person is underweight. Third, an individual is concerned with disturbance in the body image or perceived weight of the individual.⁶⁶ There is undue influence of self-evaluation with body weight. The fourth is the absence of menstrual period due to severe emaciation and physical illness. Alloy, *et al* appear to take in-depth interest on the characteristics of an anorexic. According to them, even though, weight loss is a crucial indicator, however it is not all cases of anorexia nervosa that involve weight loss.⁶⁷ Citing the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, they state that the cut-off line is a body weight that is less than 85 percent of what is normal for that particular person's age and height. This

⁶³ Dennis Coon, John O. Mitterer and Martini Tanya *Introduction to Psychology: Gateways to Mind and Behaviour* (Belmont, Cengage Learning Custom Publishing 2013). p.329-330

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ *Ibid*

⁶⁷ Alloy, *et al.*, *op. cit.* p.330.

condition may be because of the person's weight or simply the person is developing without gaining weight in the process. There is equally overwhelming intense fear of becoming fat, an unrealistic body image and a projection of a thin body ideal. For clinicians an individual has to fit within the established diagnostic criteria. It therefore implies that the person cannot be diagnosed as anorexic if any of these symptoms is not present. The intensely and continual preoccupation with the fear of becoming fat is a reoccurring characteristic of anorexia nervosa amongst most writers, however the mode or method of self-starvation differ. For instance, according to Gleitman, *et al*, one way of achieving self-starvation may involve eating only food that has low calorie.⁶⁸ Another method involves inducing vomiting in order to purge any food consumed, and may include use of laxatives which should facilitate weight loss. Furthermore, strenuous exercises are embarked upon; with such exercises often lasting for hours in a day tends to reduce their weight drastically.⁶⁹ This loss in body weight could get to a point as low as 50 percent of possible normal weight.

On his views of anorexia nervosa, Gottesfeld references anorexia as a psychogenic malnutrition caused by voluntary reduction in consumption of calories, which results to the experience of severe weight loss.⁷⁰ It is noted that anorexia is prevalent in mostly young females, especially the adolescents who adopt the anorexic body as a coping mechanism. Gottesfeld explains that some psychological factors that lead these young females into anorexia nervosa are the desire for revenge against their parents whom these adolescents believe are mistreating them; a need to alter their body contours to appear more sexless in order to avoid sexual contacts; a desire to

⁶⁸ Henry Gleitman, Alan J. Fridlund and Daniel Reisberg, *Psychology* (New York, WW. Norton & Company 2010). p.10.

⁶⁹ *Ibid*.

⁷⁰ Harry Gottesfeld, *Abnormal Psychology: A Community Mental Health Perspective* (Chicago, Science Research Association 1979). pp.338-339.

appear lean in order to look more insignificant or less conspicuous; and finally many experience depression which results to loss of appetite and reduction in calorific intake.⁷¹ Additionally, majority of such adolescents had been obese before and would have dieted excessively in order to achieve the desired weight loss. From a slightly different viewpoint, Feldman states that anorexia nervosa is a severe eating disorder in which the individual may refuse to eat which could result in a substantive depreciation of both cognitive and mental function.⁷² Such people would believe that their behaviour and appearance are normal and nothing unusual. The denial continues and remains unaltered even though they may be looking like skeletons. The age bracket for the people suffering from this disorder is between ages 12 to 20 years, mostly females even though few males may be involved. It is mostly people from stable homes, who are often successful, relatively affluent and attractive.⁷³

Sarason and Sarason further identify interplay of psychological, family and cultural factors as contributory to the underlying complex structure of anorexia. The genetic indication of anorexia leaves a trail that validates a biological susceptibility to anorexia because of the established patterns of family history of psychiatric problems reoccurring within a family lineage.⁷⁴ Anorexics in the binge type are more likely to abuse alcohol or drugs, and have other problems of impulse control which include stealing, come from less stable families, have more physical health problems, have more parental discord and have experienced more negative events in the recent past.⁷⁵

It is thought that genetics may play a role in developing anorexia, as the parents of

⁷¹ *Ibid.*

⁷² Robert S. Feldman, *Understanding Psychology* (Boston, McGraw-Hill Education 2014). pp.350-351.

⁷³ *Ibid.*

⁷⁴ Science News, 'Understanding Anorexia' (2015) available at <https://www.sciencedaily.com/releases/2015/02/150219101345.htm> [accessed 6th June 2019].

⁷⁵ Sarason & Sarason, *op. cit.* pp.192-193.

anorexics tend to have more incidences of mood and substance abuse disorders.⁷⁶ There are also psychological and behavioural differences, which is reflected in mood swings and lack of initiative on the part of the person starving. Although the individual is quarrelsome, indecisive, loses concern about physical appearance there is also a very high initiative, strong will, frequent period of feeling exuberant, and pride in personal appearance.⁷⁷ On the activity level, the anorexic body produces conflicting outcomes of energy levels. There are records of fatigue and physical exhaustion however such individuals also have seemingly inexhaustible energy characterised by over indulgence in physical exercises.⁷⁸ Finally, on sexual activity, anorexia is characterized by decrease in sexual fantasies, feeling of interest, inability to maintain erection for the males and cessation of menstruation for the females. The behavioural consequences for both types of anorexia are obsessive preoccupation, and feeling of great deal of stress, depression, even after successful treatment, and increasing risk of suicide.⁷⁹ Other consequences include disturbance in the body functioning such as retarded bone growth, anaemia, low body temperature, slow heart rate, basal metabolism rate, dry skin and no tolerance for cold. Some physiological changes that could follow include low level of serum potassium, which may cause cardiac arrhythmia, which is the tendency towards changing heart rate, which can result in death.⁸⁰

Alloy, *et al* further identify two subgroups of anorexia to include the restricting type and the binge-eating or purging type. The restricting type is where the person simply refuses to eat food and over-exercises in order to remain underweight. In the other

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

type, the binge-eating or purging type, the individual eats, sometimes he eats voraciously. However, the person compensates this much eating by making himself or herself vomit or by using one type of purgative or the other, such as laxatives.⁸¹ In some isolated cases, patients may report that food repels them to the extent that they never experience the usual appetites of hunger. However, most of the anorexics clearly experience normal appetites, at the early stages of the disorder, if not throughout the period.⁸² The element of unusual preoccupation with food is also present and a key element is basing their self-esteem mostly on their body shape. Fear of obesity appears to be next to low weight as the most typical feature of anorexia with such overwhelming evidence as claw-like hands, protruding ribs, and skull-like faces.⁸³

Gazzaniga and Heatherton equally add that anorexics are usually from the upper class in the society.⁸⁴ The preconception that anorexics are predominantly from the upper echelon of the society dominated the early writing of researchers in the field. However, it is recently noted that although many of these anorexics are adolescent females who wish to be thin, fewer than one percent of these actually meet the clinical criteria for anorexia nervosa.⁸⁵ Both the objective measure of thinness and the psychological characteristics indicating a very unusual obsession with food and body weight are included in the clinical criteria. As also noted by the authors, anorexics usually feel they are fat in spite of being at least 15 to 25 percent underweight. Issues of food and weight do not only permeate their lives, but also control both their

⁸¹ Alloy, *et al.*, *op. cit.* pp. 447-448.

⁸² *Ibid.*

⁸³ *Ibid.*

⁸⁴ Michael S. Gazzaniga and Todd F. Heatherton, *Psychological Science: Mind, Brain and Behaviour* (New York, W.W. Norton 2003).p.298.

⁸⁵ *Ibid.*

perception of themselves and the world around them.⁸⁶ Also viewed favourably at the onset of their self-imposed starvation, the family members and friends become worried when signs of anorexia nervosa emerge with their severely emaciated body. This is the point at which medical attention is needed to avert death from malnutrition. The difficulty in treating anorexics is obvious. Many of them still maintain they are fat or overweight, and have not attained the level of thinness they desired. One serious danger of this disorder is the health problem, which is the loss of bone density. The consequences of self-starvation are varied and have been noted as critical in some cases. Self-starvation for longer periods can result in muscle wasting, dry skin, becoming thin, dry and with brittle hair. Other side effects include dehydration, ceasing of menstruation, sleep disturbance and constipation.⁸⁷

Noting the adverse effects of anorexia nervosa, Gross notes the influence of societal norms in addition to the draw to stay thin as advancing the excessive concern for weight loss and thinness in female adolescence. There is however the negative outcome of problem the individual may experience about her menstrual status. Besides, amenorrhea is observed early in the development of anorexia nervosa.⁸⁸ Other observable problems include depression, problem with the mood, lack of sexual interest and social withdrawal. These include low blood pressure, bradycardia (slow heart rate), constipation, hypothermia and sensitivity to cold. Gross further reports that there are signs that are secondary to the low food intake by the patients.⁸⁹ Adolescents who are anorexic often develop distorted impression of body image and nourishment. When the dieting reaches the level of anorexia nervosa, the

⁸⁶ *Ibid.*, p.298

⁸⁷ *Ibid.*

⁸⁸ Richard Gross, *Psychology: The Science of Mind and Behaviour* (London, Hodder Education 2015) pp.772-773.

⁸⁹ *Ibid.*

individuals involved are likely to experience low self-esteem. This becomes more prevalent for groups that have much regard for weight and appearance. Gross notes that anorexia nervosa has the highest rate of mortality of any psychiatric disorder, which includes alcoholism and depression.⁹⁰

Anorexia nervosa “is notoriously difficult to research and treat”.⁹¹ The understanding of the dimensions, causes and symptoms of anorexia is not straight forward as many people suffering from anorexia are described as being chronically ill and near mortality.⁹² Various writers present keen and general perspectives and arguments on the severity of the complications or health implications of patient-centred anorexic body. However, engaging in wider narratives of underlying meaning and low recovery outcomes are underserved. Medically, it is easily deciphered as the definitions of anorexia are tailored within the refined spectrum of standard disease diagnosis. Similar to other diagnosable disorder, the preoccupation of clinicians and researchers alike are dominated with treatment options and every other accompanying factor undervalued. The clinical position embraces the narrative of the body suffering because of a defect in the mental state. Here the issue of anorexics appear simple – once the mental state is treated then the body will abate suffering and recover. In-depth analysis has shown the difficulty in past and present management of the various dimensions of anorexia. Early researchers have embraced established medical framework for treating anorexia as being in their best interest without considering other social, cultural or political factors. The medical approach is static and has recorded some effective interaction. However, engaging with new meaning for

⁹⁰ *Ibid.*

⁹¹ Science News, ‘Understanding Anorexia’ (2015) available at <https://www.sciencedaily.com/releases/2015/02/150219101345.htm> [accessed 6th June 2019].

⁹² Gross, *op. cit.* p.772.

anorexic behaviour has become pertinent in today's society. First, all definitions of anorexia have already established core medical narrative, example, psychological/mental underpinnings, societal, media/cultural relevance and genetic/biological components. All these aspects are crucial to understanding the multifaceted moving parts of anorexia; however, the objective of finding meaning outside the medical model is redundant and dismissed within the narrative. An innovative approach outside the medical field will endeavour to establish subjective meaning outside the current medical model by engaging the body as the subject not the object. The preoccupations of the feeding patterns of the individual are intertwined with severe psychological extremities. Therefore, dialogues beyond weight gain and recovery are disengaged.

In analysing anorexia nervosa, there is a critical dissection of the significance of the psychological/ mental elements that informs the voluntary or involuntary actions of the individual. The understanding of the normal or abnormal relationship an individual has with food changes when self-starvation is evaluated through the lens of voluntary and involuntary actions. In reference to the mental or mind element, the person who starves voluntarily is impacted by food in a way that is unconnected to the constant thinking and unconsciously obsession over food. Although there is a preoccupation concerning eating food and the individual has all the listed warning signs of anorexia, there is an awareness of the significance of self starvation which continues after the person resumes eating. The dilemma is that the true form of anorexia of self-starvation is not purely established as a voluntary action since there are clinical indications of existing factors, which control the way the anorexic individual behaves or reacts to food. However, for anorexia nervosa to have meaning

transcending established warning signs and clinical intervention, there has to be recognition of elements of voluntary starvation within the spectrum. The spectrum of an individual's eating behaviour can therefore be analysed through the lens of voluntary meaningful self-starvation.

Understandably, a further suggestion of the implication of voluntary or meaning-centred starvation becomes a rights interest. The significance of food refusal and extremities of re-feeding has attracted the attention of human rights proponents as the discourse is pushed beyond the basic definitions of anorexia, weight gain and recovery. In other words, when anorexics are treated against their will for the cure of their mental illness, is the bodily integrity and autonomy also preserved in the process? Until recently, the medico-legal sphere has presented a uniformed approach in tackling psychiatric treatments of individuals with mental disorder and suggestions of anorexic bodies outside the existing controlled spectrum was novice in the field. Mental health law “provides for the involuntary detention and psychiatric treatment of persons with severe mental impairment”.⁹³ However, options for seeking alternative methods of reducing the use of force have since emerged.⁹⁴ A new approach by rights proponents for “recognition of the subjective will and preferences of persons with mental impairment has also emerged”,⁹⁵ primarily dependent on a disability plea under the Convention on the Rights of Persons with Disabilities (CRPD). Advocacy reliant on a plea of disability does not address or recognise the dilemmas of voluntary or

⁹³ Kay Wilson, ‘The Call for the Abolition of Mental Health Law: The Challenges of Suicide, Accidental Death and the Equal Enjoyment of the Right to Life’ (2018) 18(4) Human Rights Law Review p.651.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.* p.652

meaningful anorexic bodies whose individual liberties and bodily integrity are still in jeopardy.⁹⁶

1.2 Medical Model of Mental Disorder

Before the development of the first edition of the Diagnostic and Statistical Manual of Mental Disorders, the ideology that all forms of abnormal and irregular behaviour had elements of mental illness and insanity had been imprinted in the English society.⁹⁷ Therefore, in the absence of a clear scientific-based diagnostic manual, clinicians relied on the traditional one-drug/therapy-treats-all universal approach in the treatment and care of all individuals who exhibit abnormal behaviour. Historical citations from the medieval period also reveal an uncategorised and undetailed interpretation of the nature and treatment of mental disorder.⁹⁸ The basic understanding of mental disorder is, thus, traditionally dominated by significant arguments on the nature, meaning and universal implication. Numerous research outcomes demonstrate an irregular and disruptive trend in analysing the defining features of mental disorder and its peculiar patterns. Remarkably, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) acknowledges that the boundaries of mental disorder are not precise and “lacks a consistent operational definition that covers all situations”.⁹⁹ The DSM-5¹⁰⁰ described mental disorders as a psychological and behavioural pattern, which can result in death, cause pain or escalate the risk for

⁹⁶ *Ibid.*

⁹⁷ Basil Clarke, *Mental Disorder in Earlier Britain: Exploratory Studies* (Aberystwyth, University of Wales Press 1975). p.83

⁹⁸ *Ibid.*

⁹⁹ Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), available at <https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596> [accessed 20th September 2019].

¹⁰⁰ *Ibid.*

intentional self-harm.¹⁰¹ Mental disorders reflect significant dysfunction in the core cognitive and mental function of the individual.¹⁰² Fact-based definition of mental disorder consists of “statistical facts, including biomedical and statistical information” conceptualised by the need to protect the most vulnerable of humanity from both conceivable and hypothetical abuse.¹⁰³ Bingham, however, argues that the value-based definitions of mental disorder show no positive outcome, as they do not address the “status of individuals in oppressive societies and over inclusive of mental or behavioural states that happen to be negatively valued in the individual’s social context”.¹⁰⁴

Investigations into the underlying causes of mental disease have progressed from the medieval period given the influence of science and technology. However, critical questions on whether “scientific diagnosis reflects a true mental disorder” is yet unanswered.¹⁰⁵ It is stale that media-idealised body goals are embedded in western cultures.¹⁰⁶ Non-western cultures do not present evidence of body dissatisfaction based on impressions from the media. Without media impact on body image, distorted perception, self-dissatisfaction and exaggerated fears of becoming thin or obese would become non-significant cultural factors. Body dissatisfaction has been linked to the idealised images in the media, which promote thin feminine features. Western women embrace this narrative and become invested in the images and messages circulated, hence developing distorted body images and unrealistic ideas concerning how they actually look in comparison with others. This problem also applies to

¹⁰¹ *Ibid.*

¹⁰² Rachel Bingham and Natalie Banner, ‘The Definition of Mental Disorder: Evolving but Dysfunctional’ (2014) 40(8) *Journal of Medical Ethics* p.537.

¹⁰³ *Ibid.*

¹⁰⁴ *Ibid.*

¹⁰⁵ *Ibid.* p.538.

¹⁰⁶ K.J. Simpson, ‘Anorexia Nervosa and Culture’ (2002) 9(1) *Journal of Psychiatric and Mental Health Nursing* pp.65-67.

adolescent girls immersed in fashion magazines culture who endeavour to attain the perfect body. Attaining the ideal thin body becomes a reward in the quest for perfection and self-control. Szasz, for instance, believes that mental disorder remains a metaphor and myth not representing or belonging to a real class of medical disease, rather a carefully crafted conception of clinicians to further the agenda of paternalistic control.¹⁰⁷ The justification for the application of involuntary therapeutic remedies is built on the reasoning that acquiring traditional medical training and expertise is sufficient to impress paternalistic control. Consequently, Szasz argues that mental illness becomes the justification for the incarceration of individuals who by law are not criminals and therefore need not be detained.¹⁰⁸ Involuntary intervention is therefore presented attractively as restorative and beneficial to the human body, regarded as weak and spiritually unstable.¹⁰⁹ A narrative that embraces established involuntary treatment methods is consistent with presumptive labelling and stereotyping accepted by legislators, jurists, and physicians. Embracing this established presumptive labelling transitions the patient into an inmate, “his prison into a “hospital”, and his warden into a “doctor”.¹¹⁰

Critical observations disclose a lack of certainty on what constitutes bodily disease and which accrues to a level of un-diagnosable brain disorder. In practice, clinicians will include varying irregular and commonly criticised behaviours as constituting mental illness.¹¹¹ Another highlighted problem in understanding mental disorder

¹⁰⁷ Thomas Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (London, Routledge and Kegan Paul 1974) pp.ix-x.

¹⁰⁸ *Ibid.*

¹⁰⁹ Andrew T. Scull, ‘From Madness to Mental Illness: Medical Men as Moral Entrepreneurs’ (1975) 16(2) *European Journal of Sociology* p.218.

¹¹⁰ Szasz, *op. cit.*, pp.ix-x.

¹¹¹ *Ibid.*, p.xii.

shows an established dualist approach between mental and physical symptoms. In many ways, the biological person - “the body”, is excluded from the narrative, as the focus placed on neurological imbalance would form the basis of disordered behaviour and thinking.¹¹² The challenge is to determine whether the medical label of mental disorder is designed to validate psychiatric paternalism and coercion or purely targeted towards wellness and recovery with no negative outcomes. Szasz objects to any core principles which furnish involuntary psychiatric intervention thereby advocating for a complete abolition. Thus, according to Szasz, the idea that a person should forgo their liberty and accept any form of involuntary treatment is “morally distasteful and legally dubious”.¹¹³ The question then is why the treatment of mental disorder should be different from the treatment of other types of illness, which does not have any special provision under the law.¹¹⁴ To this question, Szasz argues that mental illness does not exist and irregular behavioural patterns reflect the constant battle of an individual to exist and live freely and independently. The individual should be fully liable for his action, choices and decisions. The implication is that discrediting and dissecting the term mental illness might offer some much-needed meaning.¹¹⁵ First, clinical definitions of mental disorders are rounded on the analysis of the malfunction of the brain, entirely reliant on a medical, diagnostic model, thus isolating other substantive narratives.¹¹⁶ According to Szasz:

“We call people physically ill when their body-functioning violates certain anatomical and physiological norms. Similarly, we call people mentally ill when their personal conduct violates

¹¹² *Ibid.*, p.12.

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ *Ibid.*, pp.12-13.

¹¹⁶ *Ibid.*

certain anatomical and physiological norms, similarly, we call people mentally ill when their personal conduct violates certain ethical, political and social norms.”¹¹⁷

Psychiatric historians envisioned that the challenge would entail creating a viable system of classification and diagnostic evaluation, which invariably can establish treatment options as well as maintain a progressive framework, which can sufficiently tackle any idiosyncrasies that may arise within the spectrum.¹¹⁸ At this stage, for psychiatrists to achieve the required outcome, biological signals must trump cultural constructs.¹¹⁹ It, therefore, follows that the emergence of strong psychiatric monopoly occasioned a notable transition from analysing all forms of mental illness from a spiritual or demonic perspective “towards a conception of it as illness with progress of science”.¹²⁰ Towards the eighteenth century, the redefinition of insanity and other forms of mental illness within the English society gradually emerged. In the first place, legal recognition of insanity through authoritative diagnosis transition necessitated the first departure from a “culturally defined phenomenon afflicting an unknown”.¹²¹ Also, the co-dependency relationship between psychiatry and mental disorder was gradually emerging; symbolic is the institutionalisation of individuals in asylums as the definitive solution to treating lunacy or madness.¹²² Labelling the insane enhanced stereotypes, ensuring that moral boundaries were consistently drawn resulting in the exclusion and seclusion of individual possessing unique and unusual

¹¹⁷ *Ibid.*, p.17

¹¹⁸ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders -Fifth Edition DSM-5* (Washington, American Psychiatric Publishing 2013) p.5.

¹¹⁹ *Ibid.*, p.2.

¹²⁰ *Ibid.*, p.221.

¹²¹ Scull, *op. cit.*, p.218.

¹²² *Ibid.*

traits of behaviour deemed aggressive or damaging.¹²³ In the mid-eighteenth century, the psychiatric monopoly in the treatment of the mentally ill was fully formed hence the transfer of care and responsibility from the family and community to the clinicians. Scull notes that the psychiatrist capitalising on their presumed scientific expertise will assume the role of identifying the problem and providing the solution for management.¹²⁴

In what follows, the powers and control of the psychiatrists gradually emerged to prominent standing with unrestrictive authority to upgrade or downgrade the status of the mentally ill.¹²⁵ Following the removal of the cultural and moral approach, an inherited traditional disease-focused approach in treating and managing mental illness was developed around the 19th century, which was when enthused alienist engaged in the understanding, management and treatment of mental diseases.¹²⁶ Evidently, there was a need for a more cohesive psychiatric classification system supported by numerous studies and extensive scientific, medical and clinical research to aid the better understanding of mental disorder.¹²⁷ The objective for practitioners was to produce a conceptual framework based on both neurobiological and psychological traits.¹²⁸ A system of descriptive psychopathy (DP) was utilised “to record the symptoms of mental disease, and it consists of a vocabulary, a syntax, assumptions about the nature of behaviour and some application rules”.¹²⁹ The desirable outcome of the recommended DP will retain the professional medicine framework by unravelling the causative biological signal thereby delivering credible knowledge to

¹²³ *Ibid.*, p.219.

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*, p.221.

¹²⁶ German E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge, Cambridge University Press 2002) pp.1-3.

¹²⁷ American Psychiatric Association (“APA”), *op. cit.*, p.5.

¹²⁸ *Ibid.*

¹²⁹ APA, *op. cit.*

aid research and diagnosis for treatment.¹³⁰ Similar medical accounts produced a mesh of theory bound conceptual presentations involving clinical observations, indeterminate variations of biological and psychosocial elements.¹³¹ However, the challenge remained that not all predetermined factors can be accounted for during the process and there is a difficulty in analysing the information presented during the original description in the instances of treatment failure.¹³²

International classification of diseases (ICD) was therefore first developed to enable effective cross-national communication within multiple fields – including law, medicine and psychiatry.¹³³ The DSM-5¹³⁴ provides the current break down of all mental disorders delivering “a classification system of mental disorders with associated criteria designed to facilitate more reliable diagnosis of the disorder”.¹³⁵ For the psychiatrist, the DSM-5 provides a consensus on the most concise and practical reference for clinical exercise within the field, including the knowledge and awareness of the intricacies of the disorder to facilitate proper management and treatment.¹³⁶ According to Vahia, the DSM-5 “is a document that reflects current consensus of the leading academicians, clinicians, and researchers in the field of mental health.”¹³⁷ The broad objective of the DSM-5’s classification system was to assert boundaries and limitations in identifying the various forms, patterns and irregularities of disordered behaviours.¹³⁸ In addition to the provision of a standard

¹³⁰ *Ibid.*

¹³¹ APA, *op. cit.*

¹³² *Ibid.*

¹³³ R.L. Spitzer and P.T. Wilson, ‘A Guide to the American Psychiatric Association’s New Diagnostic Nomenclature’ in A.M. Freedman and H.I. Kaplan (eds), *Diagnosing Mental Illness* (New York, Atheneum 1972) p.190.

¹³⁴ APA, *op. cit.*

¹³⁵ *Ibid.*, p.xli.

¹³⁶ *Ibid.*

¹³⁷ Vihang N. Vahia, ‘Diagnostic and Statistical Manual of Mental Disorders 5: A Quick Glance’ (2013) 55(3) *Indian Journal of Psychiatry* p.220.

¹³⁸ *Ibid.*

framework for defining mental disorders, the DSM-5 specifies the general diagnostic criteria for clinical detection, evaluation and management of eating disorder.¹³⁹

The American Psychiatric Association (APA) intended to create a reliable categorisation system, which can assume universal applicability across the field of mental health as well as other broadened field of research. In essence, it was essential to develop a uniform and universal approach in the communication of the fundamental characteristics of mental disorder for active and productive engagement between clinicians and mentally disordered individuals. The issue, however, is that the boundaries between several disorders are not defined and multiple disorders may exhibit the same symptoms over time. While the DSM-5 aims to produce reliable outcomes, it has been criticised for enabling a system that focuses firstly on the recognition of the more noticeable symptoms during diagnosis, therefore, understating the cluster of less prominent symptoms which in retrospect should form a broaden spectrum which can fulfil the correct diagnostic criteria.¹⁴⁰ Major structural problems are reflected in the multiplicity of the disease an individual can suffer hence reducing specific symptoms to represent a particular illness might produce a false definite diagnosis. A more valid approach will ensure that a cluster of disorders is analysed to “maximize their validity and clinical utility”.¹⁴¹ This approach, however, means that “individual disorder diagnostic” criteria are forgone and cannot be validated.¹⁴² A more fluid diagnostic concept indicates that clinicians can adopt multiple diagnostic approaches, which further individual understanding of the multifactorial nature of mental disorders.

¹³⁹ *Ibid.* pp.220-221.

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*

¹⁴² *Ibid.*

The challenge remains the theoretical interpretation of mental disorders in this field, which mainly focuses on the psychiatric and medical aspects of the disease, precisely highlighting the effects on the mind and physical body of the individual.¹⁴³ Recently, the objectives of clinicians have extended beyond aiding knowledge in the field but also the identification of “the characteristics of specific disorders and their implication for treatment and research”.¹⁴⁴ The language of psychiatry is therefore weary to accommodate the existence of changing norms outside the standards presented by statistical manual (upgraded DP) hence further cementing the isolated and private grounds of professional medicine. Having adopted a clear paternalistic stance, psychiatric accounts of diagnosis and treatment of mental disorders are dominant, increasingly leading to silent embargos on any contradictions to the traditional established knowledge. It is noted that outlined patterns in the study of mental disorders trend on established diagnostic and classification models made for mainly clinical application and implementation regardless of the increased legal and ethical arguments. It, therefore, follows that engaging with other frameworks outside the psychiatric spectrums can be reactive, increasing criticisms of the essence and value of non-medical or bioethical interventions.

1.3 Mental Health Act 1983 (United Kingdom)

The Mental Health Act 1983 established that involuntary treatments are crucial in the management and care of the anorexic body; however such application can only be

¹⁴³ Dan J. Stein, Katharine A. Philips, Derek Bolton, K.W.M. Fulford, John Z. Sadler and Kenneth S. Kendler ‘What is a Mental/ Psychiatric Disorder? From DSM-IV to DSM-V’ (2010) 40(11) *Psychological Medicine* pp.1759-1760.

¹⁴⁴ APA, *op. cit.*, p.5.

fulfilled through legal means.¹⁴⁵ Invariably, the care, treatment and detention of individuals established to be mentally ill is enforceable without obtaining consent.¹⁴⁶ Clinicians have however extended the management and treatment of mental disorder to include addressing physical deterioration as relevant to restoring mental stability. The Act also provides that medical treatment must include nursing care and rehabilitation, which generally must be under medical supervision. Section 3.3 of the Mental Health Act 1983 code of practice defines mental disorders to include “eating disorders, nonorganic sleep disorders and non-organic sexual disorders.”¹⁴⁷ It therefore means that the medical treatment, assessment for treatment and care of patients who are established to have eating disorders such as anorexia nervosa or bulimia nervosa or other forms of eating disorder are regulated under the provisions of the Mental Health Act 1983.

The 1983 Mental Health Act provides that patients may be admitted to the hospital for assessment and treatment of their mental disorders. Where an application for such admission for assessment and treatment has been made, the grounds for the application may be that the persons is suffering from a mental disorder that requires detention for assessment of the state of their mental health and such detention should be for their own safety or the safety of others.¹⁴⁸ In *Riverside Mental Health v Fox*, the application for detention or compulsory treatment would therefore be based on

¹⁴⁵ Rosalyn Griffiths and Janice Russell, ‘Compulsory Treatment of Anorexia Nervosa Patients’ in Walter Vandereycken and Pierre J.V Beumont, (eds.) *Treating Eating Disorders: Ethical, Legal and Personal Issues* (London, Athlone Press 1998) p.128.

¹⁴⁶ Mental Health Act 1983 s 1 (1) available at <http://www.legislation.gov.uk/ukpga/1983/20/section/63> [accessed August 17th 2019] (Herein referred to as “Act” or MHA 1983).

¹⁴⁷ Code of Practice, MHA 1983, s (3.3) available at http://www.lbhf.gov.uk/Images/Code%20of%20practice%201983%20rev%202008%20dh_087073%5B1%5D_tcm21-145032.pdf [accessed August 17th 2019].

¹⁴⁸ Mental Health Act 1983 s 2 (1)(2)(a-b).

written recommendations from two registered medical practitioners.¹⁴⁹ The MHA recommends that the period for admission for assessment should not exceed 28 days unless it is extended by further application before the end of the 28 days.¹⁵⁰ An individual may also be admitted for assessment in an emergency, where at least one medical practitioner or the nearest relative of the patient has made an emergency application. The medical practitioner should be one who is familiar with the patient and if not, should comply with section 12 relating to a single recommendation. The emergency application shall only last for 72 hours unless a second medical recommendation is received and that recommendation complies with all the requirements of section 3 and section 12.¹⁵¹

The Mental Health Act therefore regulates the manner in which people diagnosed as having any form of mental disorder are treated and evaluated.¹⁵² When individuals are detained under S.2 of the Act, S.63 provides that: “The consent of the patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering...”¹⁵³ The procedure for compulsory treatment for the cure of the existing mental disorder is a rather complex one and primarily focuses on the individual as a patient whom has lost their capacity to consent to treatment. The application for detention for the purpose of treatment is made on the grounds that the person is suffering from mental disorder and should receive treatment that can only be provided within the medical facility. Medical practitioners argue that detention for the purposes of compulsory treatment is necessary for safeguarding the health and

¹⁴⁹ Mental Health Act 1983 (2) (3), *Riverside Mental Health Trust v Fox* [1994] 1 F. L. R.

¹⁵⁰ Mental Health Act 1983 s 2 (4).

¹⁵¹ Mental Health Act 1983 s 4 (4).

¹⁵² Mental Health Act, para.63 available at <http://www.legislation.gov.uk/ukpga/1983/20/section/63> [accessed February 17th 2019].

¹⁵³ *Ibid.*

wellbeing of the individual as well as protect the safety of others.¹⁵⁴ The application must be grounded on the written recommendations of two medical practitioners.¹⁵⁵ At least one medical practitioner or the nearest relative of the patient may admit a patient for assessment in situation where an emergency application has been made. The medical practitioner should have an established familiarity with the patient and if not, should comply with section 12 relating to a single recommendation. The emergency application shall only last for 72 hours unless a second medical recommendation is received and that recommendation complies with all the requirements of section 3 and section 12.¹⁵⁶

An application can also be made for a patient that is already in hospital in which case the start of admission will be considered to be the time that the application was received. If a medical practitioner responsible for the treatment of a patient determines that an application should be made for the admission of a patient then they may do so in a written report. During the time of admission the patient may be detained in the hospital for 72 hours.¹⁵⁷ An application for admission of a patient to hospital is valid for 14 days from the last time he was examined by a medical practitioner. In the case of an emergency application this period is 24 hours from the medical examination by the recommending practitioner or from the time of the application whichever is earlier.¹⁵⁸ Applications can also be made by the nearest relative of the patient or by an approved medical practitioner. However, an application may not be made by a medical practitioner where the nearest relative to the patient has notified the practitioner or their local social services authority that they

¹⁵⁴ Mental Health Act 1983 s 3 (2)(a)(c).

¹⁵⁵ Mental Health Act 1983(3)(3).

¹⁵⁶ Mental Health Act 1983 (4)(4).

¹⁵⁷ Mental Health Act 1983 s 5.

¹⁵⁸ Mental Health Act 1983 s 6 .

object to the application or the practitioner has not consulted the nearest relative. The nearest relative does not need to be consulted where it is not practical or would result in unreasonable delay.¹⁵⁹ The practitioners who personally examined the patient must give the recommendation that supports the applications. Where the practitioners examined the patient separately, the examinations should not be more than 5 days apart. The practitioner cannot give a recommendation where there would be a potential conflict of interest.¹⁶⁰ Where a local services authority feels that a patient in their area may require admission to a hospital they will appoint a medical practitioner to examine the patient. The medical practitioner will make the application if they determine that such an application should be made.¹⁶¹ A patient may be granted a leave of absence from the hospital where the responsible clinician determines that it is in the interest of the patient. This period may be indefinite or for a specific period or for specific occasions. The leave of absence can be extended even in the absence of the patient. The leave of absence may be revoked by notice in writing where the clinician determines that it is necessary in the interest of the patients health or safety or the safety of others.¹⁶²

The precedence established provides that the presence of mental disability renders such persons unable to think rationally or fulfil autonomous actions. The structural pattern of the Mental Health Act centers on the role of the individual as patient requiring paternalistic support. Clinicians therefore approach a self-starving individual cautionary of the long-standing notoriety of anorexia to produce fatal consequences should treatment be forgone. The mentally disordered individual profiled under the Mental Health Act is vulnerable, delicate and to a great extent

¹⁵⁹ Mental Health Act 1983 s 11.

¹⁶⁰ Mental Health Act 1983 s 12.

¹⁶¹ Mental Health Act 1983 s 13.

¹⁶² Mental Capacity Act 1983 s 17.

disabled and therefore lacks the capacity to start or complete voluntary actions. Understandably, the provisions of the Mental Health Act 1983 is intended to establish a framework which ensures that persons who are certified as suffering from any form of mental disorder such as anorexia nervosa can be compelled to undergo necessary treatment even in situations where they fail to accept the medical diagnosis and treatment options. Maclean therefore asserts that paternalistic intervention is necessary and required to validate and preserve individual autonomy especially where the individual capacity is lacking.¹⁶³ The objective of mental health law is generalised to regulate the conduct and behaviors of persons who have severe mental deficiency and psychiatric impairment. There is however no specification or in-depth definition of what level of mental and physical degradation should constitute severity for the purposes of administering the act. The *harm test* (individual is adjudged to constitute harm to themselves and the next person) becomes the only practical test relied upon by clinicians to enforce involuntary treatment. For the anorexic body, clinical and legal interference therefore justified when the pattern of feeding are significantly altered presenting a source of concern for their friends and family.

From a medical diagnosis standpoint, it is often significantly easier to evaluate what can constitute self-harm in a person, as refusal of food for extended periods has been noted to result in severe consequences. More so, how can the change in the feeding pattern of an individual affect the next person or result to their harm? The position of mental health laws always conflict concerning how to protect the interests of the individual and third party interests at the same time. Constitution of harm to oneself under the act is analysed within a one system approach that only evaluates the amount of food consumed and the length of self-starvation before arriving at a treatment

¹⁶³ Alasdair Maclean, *Briefcase on Medical Law* (London. Routledge Press 2004) p.12.

decision. Although the Act provides for detention for administering involuntary treatment, however, the lack of clarity lies in whether coercion and use of force-feeding constitute an effective treatment for mental disorder.¹⁶⁴ Detaining an individual against his will, occasioned by the use of force and other coercive methods, constitutes an interference with their “individual liberty and bodily integrity”.¹⁶⁵ Removal of free will means individuals are not at liberty to consent or not consent to actions, which require the use of force, inhuman and degrading methods as means of restoring the previous body weight. Dolan points out that there is a lack of balance between the interests the individual and what the law desires for them as clinical objectives override the demands of the individuals and only in rare cases are their demands met.¹⁶⁶ The objective of the MHA is to guarantee adequate protection and safety of individuals who lack competence, however, greater protection under section 139 was granted to medical practitioners thus exempting them from both civil and criminal proceeding for involuntary treatment except “the act was made in bad faith or without reasonable care”.¹⁶⁷ The extent of reasonable care in addressing acts of negligence is however subject to the standards indicated by a liable medical authority.

Although section 1.3 of the Mental Health Act 1983 code of practice requires that treatment professionals involuntarily treating an individual must “keep to a minimum the restrictions they impose on the patient’s liberty, having regard to the purpose for

¹⁶⁴ Peter Bartlett, ‘The Necessity must be Convincingly Shown to Exist’: Standard for Compulsory Treatment for Mental Disorder under the Mental Act 1983’ (2011) 19(4) Medical Law Review pp.514-547.

¹⁶⁵ Kay Wilson, ‘The Call for the Abolition of Mental Health Law: The Challenges of Suicide, Accidental Death and the Equal Enjoyment of the Right to Life’ (2018) 18(4) Human Rights Law Review pp.651-653.

¹⁶⁶ Bridget Dolan, ‘Food Refusal: Forced Feeding and the Law of England and Wales’ in W. Vandereycken and P.J.V. Beumont, (eds) Treating Eating Disorders. Ethical, Legal and Personal Issues (London, Athlone Press 1998) p.169.

¹⁶⁷ Mental Health Act 1983 pt 10 (139).

which the restrictions are imposed.”¹⁶⁸ Section 63 of the Mental Health Act confers the ultimate decision making power on treatment of mental disorders as there is no prerequisite consideration to furnish consent “for the medical treatment given to him for the mental disorder which he is suffering”.¹⁶⁹ The challenge is finding a balanced approach that ensures that the health and safety of the individual is preserved as well as ensuring that they possess the freedom needed for self-expression. Mental health law has been criticised for a rather rigid and restricted approach in dealing with people adjudged of having any existing mental disorders. According to Wilson “the debate has focused on the width of medical discretion by mental health law, rather than whether the discretion should exist at all”.¹⁷⁰ Section 23.32 of the MHA practice code explains that the individual is entitled to receive in-depth information on type of treatment embarked upon and the associated risks, only then can consent be given voluntarily. Invariably, “permission given under any unfair or undue pressure is not consent”.¹⁷¹

Sections 57 and 58A highlight the types of medical treatment for mental disorders which requires consent prior to medical treatments and therefore subject to special procedures.¹⁷² Treatments subject to the special procedure include neurosurgery for mental disorder, surgical implantation of hormones in order to reduce sex drive¹⁷³, medications applied after an initial three months period-except as part of giving electro convulsive therapy¹⁷⁴ and when administering electroconvulsive therapy and

¹⁶⁸ Mental Health Act 1983, s. 1.3.

¹⁶⁹ MHA 1983, s.63.

¹⁷⁰ Wilson, *op. cit*

¹⁷¹ MHA Code of Practice, s.23.32.

¹⁷² Mental Health Act 1983 ss 57 and 58.

¹⁷³ *Ibid.*

¹⁷⁴ Mental Health Act 1983 s 4 (58).

other medication as part of the ECT.¹⁷⁵ It therefore means that under Section 63 of the Act once a patient is detained, they can be treated for their mental disorder whether consent is given or not unless the provisions of sections 57, 58 and 58A apply. *B v Croydon* established that when a person continually refuses food and is subsequently detained under the Mental Health Act, the question of whether the person has capacity to consent to forceful feeding does not arise as the act invariably endorses force-feeding and does not recognize a competent persons refusal.¹⁷⁶ Section 23.37 of the Mental Health Act Code of Practice explains that the MHA intentions are to request consent from patients when feasible and seeks to ensure that medical treatments are not carried out just to treat the physical disorders of a patient except it is essential that treating the physical disorder addresses the mental disorder.¹⁷⁷ In *South West Hertfordshire Health Authority vs KB*, the judge agreed with the Hertfordshire health authority that “relieving the symptoms was just as much as relieving the underlying cause”.¹⁷⁸ It therefore means that force-feeding by nasogastric tube is a vital part of the medical treatment that relieves the physical symptoms and also serves as treatment for her mental disorder. Similarly, in *Riverside NHS Trust v Fox* forced feeding was established as a legitimate treatment for anorexia patients under the 1983 Mental Health Act.¹⁷⁹ The outstanding question, however, is whether food applied forcefully, orally or through nasogastric tubes should be regarded as a valid and legitimate treatment of a patient’s mental disorder?

It is established under the MHA that medical treatment is applied for the mental disorder from which the patient is suffering, however, the Act does not confer any

¹⁷⁵ Mental Health Act 1983 s 4 (59).

¹⁷⁶ *B v Croydon* [1994] 2 WLR 294.

¹⁷⁷ MHA Code of Practice, s.23.37

¹⁷⁸ *South West Hertfordshire Health Authority v KB* [1994] 2 FCR 1051.

¹⁷⁹ *Riverside Mental Health Trust v Fox* [1994] 1 F.L.R.

powers on medical professionals to impose treatment for any physical disorders that are unrelated to the patient's mental disorder.¹⁸⁰ The causal link between physical and mental disorder has allowed the courts to utilize this section and declare some treatments (including reasonable restraint) as lawful despite the patient's refusal. The justification had been that some physical disorders might be symptomatic of, or may contribute to the severity of, or be the cause of, some mental disorders. Invariably treating the physical disorder is in effect treating the mental disorder. Section 63 has therefore been stretched to include within its scope, forced feeding for the treatment of anorexia. Individuals established as having anorexia nervosa may be forcibly detained for treatment under Sections 2 and 3 of the MHA whether they are competent or incompetent. *A Guidance on the Treatment of Anorexia Nervosa under the Mental Health Act 1983* published by the Mental Health Act Commission instructs that for the purposes of evaluating and treating an anorexic patient, such a patient may possibly be detained under the Act. Section 63 of the MHA further provides that medical practitioners are at liberty to apply medical treatment on a detained individual regardless of whether they possess the capacity to reject treatment.¹⁸¹ Giordano argues that the problem with the MHA is that it fails to communicate what exactly can be regarded as an appropriate treatment for a mental disorder and which treatments can be legally enforceable under the act¹⁸². Bridgman points out that it is possible that Section 63 of the MHA lacks the authority to justify restraint under the law. However, at first glance, there exists an underlying connection between the physical and mental aspects of this disorder and therefore seems

¹⁸⁰ Simona Giordano, *Conceptual and Ethical Issues in the Treatment of Anorexia Nervosa and Bulimia Nervosa* (Oxford, Clarendon Press 2005). pp.198-199.

¹⁸¹ Mental Health Act 1983. s.63.

¹⁸² Giordano, *op. cit.*

plausible that the Act can enforce treatment on physical disorders connected to the treatment of a patient's mental disorder.¹⁸³

The rise of bioethics movement in the late sixties and seventies spearheaded worldwide, apprehension on the legal implication of treating detained patients without their consent. Furthermore, under the guidance of the European Court of Human Rights in Strasbourg numerous countries amended their mental health legislation between 1978-1992. In reviewing the criteria for involuntary admission in Strasbourg, “the image of the patient as a ‘citizen’ with rights’ emerged with an increased recognition that compulsorily admitted patients retained their legal rights during their stay.”¹⁸⁴ However, Dolan argues that those legal rights are non-existent especially in treating anorexic individuals as it appears legally established in England and Wales that: “patients with anorexia nervosa can be compulsorily admitted and artificially fed regardless of absence of consent under the provisions of the MHA”.¹⁸⁵ There is, therefore, still no significant recognition that a person's psychiatric disorder or compulsory detention does not render a patient unable to make valuable decisions on the matters, which affect their wellbeing.¹⁸⁶ *Re C (an Adult Treatment: Refusal of Treatment)* noted that it would be a breach of common law not to acknowledge the refusal of a competent adult to be subjected to treatment.¹⁸⁷ However, the language of the Mental Health Act reinforces labeling and stereotyping of the anorexic body as it already references the autonomous individual as a patient prior to any medical

¹⁸³ Andrew M. Bridgman, ‘Mental Incapacity and Restraint for Treatment: Present Law and Proposals for Reform’, (2000) 26 (5) *Journal of Medical Ethics* pp.387-388.

¹⁸⁴ Bridget Dolan, ‘Food Refusal: Forced Feeding and the Law of England and Wales’ in W. Vandereycken, and P. Beumont, (eds.) *Treating Eating Disorders. Ethical, Legal and Personal Issues* (London, Athlone 1998) p.175.

¹⁸⁵ *Ibid.*, p.175.

¹⁸⁶ *Ibid.* p.151.

¹⁸⁷ *Re C (an Adult Treatment: Refusal of Treatment)* (1994) 1 All ER 819.

assessment. The implication is that an individual with no established mental disorder is already identified as a person suffering and in need of medical treatment and intervention. A person is regarded as possessing their full autonomous prior to the determination of their mental state and competence to consent to medical treatment. The issue however is that this autonomous person is not allowed under the Act to take the decision on the assessment of their mental state. This step is very crucial as there is no interpretation as to when the autonomous person transitions into a patient. Section 3 of the Mental Health Act 1983 is most applicable to anorexia nervosa sufferers.¹⁸⁸ Section 3 stipulates that a patient who suffers from mental disorder in any extent “mental illness, severe mental impairment, psychopathic disorder...” may be admitted to a hospital and detained for treatment following an application for such admission.¹⁸⁹ Medical treatment that can be administered without consent includes nursing, psychological intervention and specialist mental health rehabilitation and care.”¹⁹⁰ The provisions of Section 63 of the MHA in addition to the removal of the requirement of consent implies that anorexic patients admitted under the Act would not need to furnish their consent prior to medical treatment. Invariably the instant evaluation of disordered behavior is established by accounts of physical thinness due to self-starvation. The starving body is therefore aligned with the labeling and stereotypical dominating medical analysis of anorexia nervosa. Since consent is not sought prior to assessment for the determination of their mental disorder, the person’s capacity is already in question and can therefore be subjected to involuntary treatment after assessment. Weiss however argues that autonomous adults possess the freedom

¹⁸⁸ Mental Health Act 1983 s 2(3).

¹⁸⁹ Mental Health Act 1983 s 2 (3) (1).

¹⁹⁰ Mental Health Act 1983 s 10 (145)(c).

and rational thinking to self-starve, However this may not be the case for younger women under the guardianship of their family.¹⁹¹

Various treatment methods identified under the Act indicate that medications are administered within a three months period of detention, after which the period of detention can be extended for another three month with the purpose of administering additional medical treatment. However, individuals who object to extended detention periods are forced to continue treatment under the Act. Refusal of treatment on autonomous grounds signifies the manifestation of the symptoms of mental disorder. Medical practitioners have informally noted that the presence of mental disorder prohibits rational thinking and cloud logical judgment. In evaluating the mental state of the individual, rationality is therefore a pre-condition whether the individual will accept or refuse medical treatment. In situations where the individual asserts their right to refuse medical treatment, clinicians argue that refusal of medical treatment indicates disordered behavior as a mentally stable individual would understand the extent of physical deterioration. The deteriorating physical body then becomes core recognizable criteria to evaluate the mental state of the individual especially when there is no behavioral indication of constituting harm to oneself or another person. If asserting the rights to refuse medical treatment indicates the presence of mental disorder, it is within reasoning to label the MHA as contributory to the stereotypical views of mental disorders.

Core challenges in asserting autonomy revolves around established principles under the Mental Health Act, which forgo the crucial elements of capacity once the individual is detained and conveys all authority for medical decision-making on approved medical practitioners. The justification for not requiring consent hinges on

¹⁹¹ Gail Weiss, *Body Images: Embodiment as Intercorporeality* (New York, Routledge 1999) p. 2.

section 63 of the Mental Health Act, which also creates a connection between the ethical issues that arise when consent is not required under section 2 of the Mental Capacity Act. Although the Act only references medical treatment as applicable regarding the treatment of mental disorders, clinical treatment under the Act extends to reversing the manifested physical disorder. In *George's Healthcare National Service Trust v S*,¹⁹² detention under the Act was considered unlawful although consent was not sought in administering a treatment that could preserve life. Regardless, the court found that providing life-saving medical treatment must not be for purpose unconnected to mental disorder. Consequently, detention under Section 2 of the 1983 MHA must therefore be solely connected to the treatment of mental disorders and clinicians ought to have made a distinction between the treatment administered to address the urgent treatment required by the pregnant woman and detention for her mental disorder.

Understandably legal provisions guide medical decisions therefore clinicians will have to deliberate between respecting the autonomy and “promotion of his or her welfare”.¹⁹³ The application of Section 63 of the MHA on non-consenting anorexic bodies is consistent once the individual is proven to self-starve and physical emaciation (under 17 BMI) been registered. S.63 therefore steps away from the general legal principles established under English common law that attributed all adults as competent to furnish their consent prior to any medical intervention.¹⁹⁴ However, once mental disorder is linked to physical deterioration, Article 2 (Right to life) of the ECHR is administered and arguments of preservation of life then supersede autonomous rights of the individuals. Although there is no exposed

¹⁹² [1998] 2WLR 936.

¹⁹³ Giordano, *op. cit.* p.182.

¹⁹⁴ *Ibid.* p.184.

indication that the individual is desirous of death or wishes to self-harm, clinicians however reference the long-term effects of self-starvation, which can result to death. The probability of death in this instance is not because of their mental disorder but as a biological consequence of self-starvation. Although the requirement of consent is for competent adults, the law also recognises that mental illness does not necessarily jeopardize the patient's capacity to make medical decisions.¹⁹⁵

Giordano identifies some issues with the clinical evaluation of competence in disordered eating behaviours. Firstly, Giordano asserts, "people with eating disorders are typically intelligent, and not at all the stereotypical 'insane' person, detached from reality".¹⁹⁶ It is therefore difficult to accept that refusal of medical treatment by some of them demonstrates or affirms incompetency. It is therefore problematic to accept that although the anorexic individual may show competency by understanding the information presented to them yet they are also unable to make informed decision due to the presence of mental illness.¹⁹⁷ Accepting an individual's effective fulfilment of the competency requirement in processing medical information whilst reinforcing their incompetence in making his or her own medical decision presents a very conflicting stance. There should be consideration that the clinicians would adjudge the individual of failing to understand the information disclosed because of their conflicting opinions on treatment intervention. There is also no detailed definition of how an individual is expected to prove competency by understanding and retaining information furnished by clinicians. The paternalistic setting in the management of eating disorder implies that the individual has to agree and accept the decision of the

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.* p. 193.

¹⁹⁷ *Ibid.* p.192.

medical practitioner. A conflicting stance by the individual will equate to a lack of understanding of the information and equates incompetency.

The MHA 1983 does not recognise the multifactorial nature and ever changing behavioural dynamics of the anorexic body, which necessitates difficulty to correctly apply the competence test. Self-starvation in itself reveals a great level of free will, self-denial and determination to continuously remain within a specific size. The accompanying dimensions of excessive exercise and taking slimming pills are also consciously curated to reinforce and fulfil those body specific goals. Clinical evaluations of anorexia nervosa are never done in isolation, as other symptoms not associated with self-starvation itself form part of the medical treatment. In a *NHS Foundation Trust v Ms X*, X already had a chronic dependence on alcohol, which resulted to irreversible liver damage.¹⁹⁸ X could not however be detained under Section 2 of the MHA 1983 for the treatment of her alcohol dependence syndrome. However, medical practitioners focused on a collective treatment, which involved detention for the treatment of her anorexia nervosa. The efficacy of the understanding and retention of the information presented by medical practitioners to the anorexic body cannot be positively or productively evaluated when the act of self-starvation is at its core an autonomous choice and decision to refuse food. Reinforcing feeding, as part of the treatment for anorexia will not present a logical narrative to the anorexic body as it defeats the meaningful value of their experience. Wilson notes that critics have requested an abolition of mental health laws on grounds of prejudice and “unnecessary interference with individual liberty and bodily integrity”.¹⁹⁹ It is

¹⁹⁸ *A NHS Foundation Trust v Ms X* [2014] EWCOP 35.

¹⁹⁹ Wilson, *op.cit.*, pp.652.

therefore predictable and unsurprising that mainstream rejection of third party medical decision-making is beginning to emerge.²⁰⁰

1.4 Human Rights, Bioethics and Mental Disorders

The ethical issue of stereotyping all persons adjudged as mentally ill is consistent and contentious across the field of healthcare. Pearn notes that every traditional interaction between the doctor and patient “has the potential to involve individuals in stereotypic views”.²⁰¹ Pearn defines stereotyping as ascribing the same features present in a particular individual as applicable to a whole class of people.²⁰² The practical implication in medicine is the “attitudinal tradition of medical paternalism” which establishes reduced autonomy, as the subject is deemed incapable of rationalising the diverse choices affecting their individual condition.²⁰³ The prevalent assumption is that the presence of mental illness diminishes competence and prevents patients from utilising the information presented to them in order to make the best decision. The capability of an individual to make decisions mainly affects their autonomous rights. Historically, clinicians are reluctant to engage directly with individuals once they exhibit a behavioural or psychological pattern consistent with mental disorder. Clinicians at this stage view their capacity to make rational decisions as compromised thereby reducing their autonomy²⁰⁴. Giordano firstly refutes the notion that a person’s reduced autonomy in making treatment decision is due to mental illness.²⁰⁵ Giordano insists that the law recognises that the incompetence of a

²⁰⁰ *Ibid.*

²⁰¹ John Pearn, ‘Ethical Issues of Stereotyping’ (2002) 8(2) *Journal of Professional Ethics* p.59.

²⁰² *Ibid.* p.60.

²⁰³ *Ibid.* p.64.

²⁰⁴ *Ibid.*

²⁰⁵ Giordano, *op. cit.*, pp.185

patient in an aspect of life does not mean that such a patient cannot make treatment decisions on other areas.²⁰⁶ It becomes very problematic to assume that incompetence is established once a person diagnosed with an eating disorder refuses treatment. Therefore, that an individual has a mental illness does not necessarily impair the individual's right to autonomy as most people suffering from eating disorders are very aware, able to retain the information presented to them, intellectual and often very skilled. According to Giordano:

“The fact a person has received a diagnosis of mental illness does not give us reason to assume that she is incompetent. It may instead give us reason to investigate further her capacity to consent. This position is in line with the general principles of respect for autonomy that is accepted by the UK laws.”²⁰⁷

Understandably, humankind is generally affected by any decisions with ethical implications in the field of medicine, science and technology.²⁰⁸ The socio-cultural diversity of human beings means that ethical dilemmas that arise from an illness or disease cannot be effectively appraised by relying only on the standard statistical framework guidelines presented in professional medical practice.²⁰⁹ In reality, some scholars argue that the values that reflect human rights thinking exist outside the core roles of physicians, but “...it goes further much further than the various professional codes of ethics concerned”.²¹⁰ Essentially, psychosocial and cultural factors are also

²⁰⁶ *Ibid.*

²⁰⁷ Giordano, *op. cit.*, p.193

²⁰⁸ United Nations Educational, Scientific and Cultural Organization (“UNESCO”), ‘Universal Declaration of Bioethics and Human Rights’ (2005) available at http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html [accessed 3rd August 2019].

²⁰⁹ Arthur L. Caplan, ‘The Birth and Evolution of Bioethics’ in Vardit Ravitsky, Autumn Fiester and Arthur L. Caplan (eds.) *The Penn Center Guide to Bioethics* (Pennsylvania, Springer Publishing Company 2009).

²¹⁰ UNESCO, *op. cit.*

feasible and potent factors in health analysis as opposed to sole reliance on scientific and technological factors.²¹¹ With advancement in knowledge and fact-finding, it is expected that conflict will arise in medical, ethical and socio-legal realms.²¹² Bioethical approaches, therefore, provides the intersection to addressing both legal and ethical issues and “contribute concepts and values that may be imported into legal rules, case laws, and statutory obligations”²¹³ Credibility in analysing, interpreting and implementing traditional bioethical principles therefore, arrived through human rights.²¹⁴

A conceptualised bioethical principle such as “Autonomy, Beneficence, Justice and Non-Maleficence” has merged into the theory and practice of human rights.²¹⁵ The United Nations Educational, Scientific and Cultural Organization (UNESCO) referencing the 1948 Universal Declaration, 1997 Universal Declaration of the Human Genome and Human Rights and the 2003 International Declaration on Human Genetic Data conceptualised the Universal Declaration on Bioethics and Human Rights.²¹⁶ The 2005 Universal Declaration on Bioethics and Human Rights reflected on the clarion call of providing a sustainable response to the ethical challenges precipitated by modern advancement in science and technology.²¹⁷ UNESCO General Conference recognised that these ethical dilemmas “...should be examined with due respect for, and observance of, human rights and fundamental freedoms”²¹⁸ and

²¹¹ *Ibid.*

²¹² George P. Smith, *Law and Bioethics Intersection along the Mortal Coil* (Abingdon, Routledge 2012) pp.2-3.

²¹³ Barry R. Furrow, ‘Health, Law and Bioethics’ in Vardit Ravitsky, Autumn Fiester and Arthur L. Caplan (eds.) *The Penn Center Guide to Bioethics* (Pennsylvania, Springer Publishing Company 2009).

²¹⁴ *Ibid.* p.4.

²¹⁵ Smith, *op. cit.*

²¹⁶ UNESCO, *op. cit.*

²¹⁷ *Ibid.*

²¹⁸ *Ibid.*

resolved to provide a productive base for the resolution of the rapidly expanding challenges.

Traditional bioethics doctrines address the doctor–patient relationship by analysing the morals behind medical treatments. The doctor-patient dynamic has often emerged as one of the core challenges in health care especially within the context of involuntary treatments. The fundamental dilemmas that arise once the individual refuses treatment raise strong legal and ethical concerns. Establishing a framework that offers independent guidance to behavioural patterns without the influence of undue coercion or restrictions becomes a matter for clinical concern “bearing in mind that a person’s identity includes biological, psychological, social, cultural and spiritual patterns”.²¹⁹ In essence, as the shift from strict professional medical framework occurs, the legal arena becomes active as the courts rely on the substantive principles of bioethics to redefine and analyse the ethical challenges. First, within the bioethical purview, the identity of the individual is recognised in the sense that preserves their dignity and fundamentally upholds their human rights. Article 3(1) of the Universal Declaration of Bioethics and Human Rights provides for the full respect of human rights and fundamental freedoms.²²⁰

It therefore follows that the priority of the welfare and interests of the individual supersedes “sole interest of science or society”.²²¹ Regardless of the merits of preserving dignity and protecting human rights, Brody considers the right to autonomous self-determination as an abstract concept that does not represent the best interest of the individuals especially in particular cases where actions or occurrences

²¹⁹ *Ibid.*

²²⁰ *Ibid.*, Article 3(1).

²²¹ *Ibid.*, Article 3(2).

that might lead to death are involved.²²² The difficulty in applying autonomous rights arise from the ethos that insists that the presence of mental disorder signifies the lack of sound mind, which invariably reflects the lack of opportunities and choice.²²³ Rationality on moral grounds does not consider mentally ill individuals as having free will and independence.²²⁴ It follows that a mentally impaired individual has no clear awareness of their actions and consequently cannot logically and rationally evaluate the result of their actions. Regardless, basic dignity and respect should be accorded notwithstanding their moral worth.²²⁵

In the last century, the principle of autonomy has anchored its substance within the fundamental core foundations of human rights.²²⁶ Essentially, patient rights movements have anchored the advocacy for self-determination as integral to a progressive modern day.²²⁷ Personal autonomy extends further to the respect of free choices and the actions of others. It is underlying the quest for “self-ownership and governance”, informed consent, respect of choices and voluntary decision-making recognising moral values.²²⁸ Smith argues that although it is essential that individuals express their choices independently and voluntarily, however, there are circumstances when such a power can be transferred to a medical expert during treatment.²²⁹ Essentially, a determination is made not only regarding the autonomous nature of the individual but also on the ways to include and engage the relevant past decisions, expressions and inclinations.²³⁰ Analysing autonomous rights circles to the

²²² Brody, *op. cit.*, p.177.

²²³ Janice Connell, Alicia O’Cathain and John Brazier ‘Measuring Quality of Life in Mental Health: Are We Asking the Right Questions?’ (2014) 120 *Social Science and Medicine* pp.12-20.

²²⁴ Brody, *op. cit.*, p.179.

²²⁵ *Ibid.*

²²⁶ Smith, *op cit.* pp.21-22.

²²⁷ *Ibid.*

²²⁸ *Ibid.* pp. 37-40.

²²⁹ *Ibid.*

²³⁰ *Ibid.*

“justification in overriding a patient’s present autonomous choices or actions in light of his past or (anticipated) future choices and actions”.²³¹ Smith notes that in various settings, depending on the prevalent condition of non-autonomous persons, the likelihood of overridden autonomy is very much heightened.²³²

The principle of autonomy, therefore, highlights individual ownership of decision-making. Article 5 of the Universal Declaration of Bioethics and Human Rights provides for the right of individuals to “...make decisions, while taking responsibility for those decisions and respecting the autonomy of others.... For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests”.²³³ It implies that for all thoughts and purposes, authority over their mind, body, decisions and actions without any external influences. Regardless of the negative or positive moral standing of the third party, conflicting positions will arise when the individual is adjudged incapable of utilising their autonomous rights. However, Article 6(1) provides for extending the right for individuals to give informed consent before any decision that affects their mental and physical wellbeing.²³⁴ Article 6(1) further states:

“Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate be express and may be withdrawn by the person”.²³⁵

²³¹ Smith, *op cit.* pp.71-72.

²³² *Ibid.* pp. 21-22.

²³³ UNESCO, *op. cit.*, Article 5.

²³⁴ *Ibid.*, Article 6 (1).

²³⁵ *Ibid.*

Autonomy then conflicts significantly with the beneficence requirement of ensuring that the most effective quality medical care is administered even in situations where the individual regards such treatment as degrading and not in their best interest. Autonomy has become acknowledged as the foremost principle in medical ethics. Backed by case law and legislation, there is recognition that competent adults can accept or decline valuable life-saving medical treatment. A non-maleficence stance enables the doctors to step in to ensure that those decisions are in the individuals best interest and not harmful regardless of the legal and ethical considerations. The extent to which doctors are allowed to make certain difficult decisions and the ethical considerations for such decisions are often one of the challenges the courts face. Resolving the conflicts that arise in medical practice would necessitate the courts to engage equally the traditional settings of ethics, common law and medicine.

Understandably, both the patient and the doctor would rely on the outcome (judicial decisions) to formulate a new attitude to conflicts that arise within healthcare. Invariably, the scenario provides that judicial resolution of these issues would pull from formulated principles using applicable legal tools. Customarily, the doctor-patient relationship is always ethically scrutinised. The fiduciary duty of doctors ensures that the safety of patients is at the core of their professional obligation and integrity. The doctrine of informed consent forms an essential aspect of the relationship although conditional on the level of competency and capacity exhibited by the individual. The appeal for human dignity is a controversial one when viewed in light of competency. Clinicians often ensure they abide by the ethics of their profession in caring and managing the individual to recover from an illness, rather than fully acknowledging the appeal for the recognition of the principle of human dignity and self-worth. Recognising an individual as a rational agent justifies their

actions and the choices they make.²³⁶ Accordingly, the right thing to do is what an individual chooses, the right they have to express themselves freely, which appeals to Kantian ideologies of “justice to each persons will”.²³⁷ Free will therefore sometimes does not hinge on good or bad but on what an individual purports to be in their best interest.²³⁸

The apparent argument for force-feeding and the use of coercion in doing so on moral grounds have exhausted itself, and selective interpretation fails to gather the definitive conclusions needed to anchor human dignity on the survival of human rights. The United Nations’ General Assembly in 1948 confronted the reality of systematic discrimination recognising “the inherent dignity and the equal inalienable rights” as the bases of “freedom, justice and peace”.²³⁹ Although the universal declaration are not binding, the essence was reflected in setting the parameters for human rights to flourish. This development created a “culture of human rights, and the states became inclined to adhere to the boundaries set without compromise”.²⁴⁰ The challenge, however, was the independence of states and government as sovereign and therefore cannot be compelled to codify, implement and sustain the realisation of human rights. States can, therefore, assume some obligation as shaped under international human rights through the implementation of international treaty documents.²⁴¹ The United Nations’ intent in drafting the Universal Declaration of Human Rights was to recognise the inherent aspiration of every man to attain a place of freedom without the fear of oppression and also the ability to access the protection guaranteed by the rule

²³⁶ Garrath A. Williams, ‘Praise and Blame’ available at www.iep.utm.edu/praise/ [accessed 2nd August 2019].

²³⁷ *Ibid.*

²³⁸ *Ibid.*

²³⁹ Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (Pennsylvania, University of Pennsylvania Press 1999) p.10.

²⁴⁰ Smith, *op. cit.*

²⁴¹ *Ibid.*

of law.²⁴² By interpretation, the United Nation General Assembly envisioned the idea of human dignity grounded in the appreciation of free will and the implementation of equality and dignity to the ethical or moral standing of individuals having been “endowed with reason and conscience”.²⁴³ Regardless of the distinction between individuals, the basis for this distinction being “race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or status”.²⁴⁴ Everyone has “the right to life, liberty and security of person”.²⁴⁵ Some decisions impact a person’s life, and realising those values mirror the internal questions of the value of human life.²⁴⁶ According to Harris, “[i]n a free society, individuals must be allowed to make these decisions for themselves, out of their faith, conscience and convictions”.²⁴⁷ Dworkin also notes that the most severe feature of slavery was the denial of the rights to make decisions, which individuals value, and respect.²⁴⁸ In every sense, when confronted with the worst atrocities known to humanity – the actions that arise from the neglect of human rights is grave. In Dworkin’s mind, the abolitionist intention of rescuing slavery and servitude was to restore dignity and self-worth.²⁴⁹

Multiple interpretations of human rights strongly reflect the accepted code of conduct of one person as it affects the next person. However, the unrestricted use of power remains vague in the systematic interpretation of informed consent. The

²⁴² William A. Schabas, *The Universal Declaration of Human Rights: The Travaux Préparatoires* (Cambridge, Cambridge University Press 2013) p.cxiii.

²⁴³ United Nations, Preamble to The Universal Declaration of Human Rights available at http://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf [accessed 3rd August 2019].

²⁴⁴ *Ibid.*, Article 2.

²⁴⁵ *Ibid.*, Article 3.

²⁴⁶ John Harris, “‘Goodbye Dolly?’” *The Ethics of Human Cloning* (1997) 23(6) *Journal of Medical Ethics* pp.353-360.

²⁴⁷ *Ibid.*

²⁴⁸ Ronald Dworkin, ‘Unenumerated Rights: Whether and How Roe Should be Overruled’ (1992) available at <http://www.scribd.com/document/34385810/DWORKIN-Ronald-1992-the-Concept-of-Unenumerated-Rights> [accessed 4th January 2019]. p.45.

²⁴⁹ *Ibid.*

recommendations of the medical professionals are overriding so far the individual is made aware. Contextually, based on the interpretation of human rights, dignity and freedoms are allotted to an individual by the nature of being human. By corollary, they can be removed, displaced or also oppressed by the nature of their being human beings. For Brody, inherent rights and dignity succeed when the individual can exhibit or show reasonable competency to embrace the functional aspects of their life. In perspective, the conflict will resonate from the understanding of the nature of rights and the implications for every single individual.²⁵⁰ In this regard, if rights are universal, there is no assumption as to what these rights mean to an individual and in what ways they can be legitimately reflected and claimed. In many ways, there is an interception between culture that signifies a way of life and the meaning underlying behaviours, which forms part of human nature.²⁵¹

²⁵⁰ Brody, *op. cit.* p.2.

²⁵¹ *Ibid.*

CHAPTER TWO

Behavioural Substructure

2.

The previous chapter analysed the discrepancies in the definition of anorexia especially the overview and evolution of the medical model of what constitutes mental disorder and how this extended and generalised dimensions challenge the implementation of autonomy or autonomous actions under the Mental Health Act. It therefore follows that although the structural patterns of the MHA 1983 centres on the role of individual as a patient, for the self starving individual, the viable system of evaluating their unusual or abnormal eating pattern does not present an accurate profile which is reflective of the underlining behavioural pattern within a meaningful individualised narrative. Chapter 1, therefore, provided the crucial structure in rethinking the overall stereotyped definition of anorexia for understanding of the argument for self-starving individuals to exist meaningfully, freely and independently. This current chapter starts with a synopsis of the underling structures of behavioural models that sufficiently reveal the different realities of anorexia. The aim is to examine the multiple variables that underscore abnormal behaviour beyond the criteria specified in the Diagnostic and Statistical Manual of Mental Disorder in order to present a different reality representing an individualised way of life and experience. The discussion in this chapter provides the background for analysing the challenges of conceptualization of the anorexic body especially in regards to current thinking and approach to mental health practice and values. In light of

understanding the behavioural models, a systematic analysis of the emerging notions of body image and self-starvation is discussed with the aim of approaching disordered behaviour from alternative perspective rather than pathology.

2.1 Behavioural Models

The discrepancies in defining the concepts of illness and disease significantly reveal the different realities in understanding anorexia nervosa. Usdan and Lewis attempt to differentiate between the concepts of illness and disease.²⁵² According to them, disease may be defined in chemical and cellular terms, with the assumption that only the symptoms that can be observed or related directly to underlying physiochemical processes are acceptable. The definition does not recognise illness in a clinical sense, rather illness is referenced as what a person experiences.²⁵³ Illness is therefore “something a man has”²⁵⁴ beyond their biological anatomy. The contention is that medical doctors treat only the disease neglecting the person and their individualised illness, which is a culmination of their experiences. However, it has also been noted that a disease can constitute an illness.²⁵⁵ Illness can be understood from two perspectives. One is the adaptive consequence of the illness, while the other is the illness behaviour itself.²⁵⁶ Illness cannot be said to be random phenomenon, as a

²⁵² Gene L. Usdin and Jerry M. Lewis, *Psychiatry in General Medical Practice* (New York: McGraw-Hill 1979) pp. 34-56.

²⁵³ *Ibid.*

²⁵⁴ Cecil G. Helman, ‘Disease Versus Illness in General Practice’ (1981) 31(230) *The Journal of the Royal College of General Practitioner* p.548.

²⁵⁵ Usdan et al. *op. cit.*

²⁵⁶ *Ibid.*

percentage of illnesses tends to concentrate in a small percentage of individuals and the particularities cluster in time.²⁵⁷

Affective responses to situations in life that are stressful and difficult, such as loss of loved one, major changes in an individual's life situation, could cause such people different illnesses. In a sense, members of a family where there is poor communication, fighting, less love and care for stress tend to be vulnerable to illness. Multiples variables interface as a response to effective situations necessitating focus on several factors in order to understand the illness of particular patients. For instance, a person experiencing poor health is hospitalised for complaining of a chest pain, with subsided pain and no tissue damage; however, examination revealed there was a multiple vessel coronary atherosclerosis.²⁵⁸ The treatment for the disease was limited to the underlying coronary artery disease whilst other possibilities or factors were neglected.²⁵⁹ These overlooked factors included the fact that the patient was tense, overly perfectionist and hard driving.²⁶⁰ There is also the consideration of other multi factorial circumstance surrounding the hospitalisation outcome, which might include the development of a recurring malignancy, confrontation with the teenage daughter about the company she kept and drug use. Other contributory factors may include dealing with opposition from obese wife who was taking mild tranquiliser against his intention to accept a recent promotion that would make him travel more.²⁶¹ The interplay of these difficulties made the man increasingly tense, insomniac and conflicted, which resulted to the chest pain. In this case, the disease was clearly the coronary atherosclerosis while the other situational variables constituted part of the

²⁵⁷ *Ibid.*

²⁵⁸ Usdan et al. *op. cit.* pp.38 -40

²⁵⁹ *Ibid.*

²⁶⁰ *Ibid.*

²⁶¹ *Ibid.* pp. 55-56

man's illness.²⁶² The case of this man with chest pain suggests that there are physical illness and another type of unaccounted illness. Mental illness presents a state that involves the underlying identifiable physical defects and behavioural problems triggered by environmental factors surrounding and influencing the individual.

Investigators and theoreticians reveal that it is insufficient to analyse or assess mental health on the general label. Functional definitions of mental health focus on established standards in terms of the positive striving through which an individual grows, matures, and accepts responsibilities as well as successfully coping and finding fulfilment.²⁶³ A mentally healthy person therefore develops intellectual abilities, work skills including social sensitivity. Jahoda explains that there are three fundamental aspects of mental health.²⁶⁴ First, the active adjustment involves attempts at mastering the environment; unity of personality and stable integration of experience, and the correct perception of the world and self, irrespective of personal needs.²⁶⁵ The question remains, why these investigators and theoreticians should choose to define mental health in a way that unidentified or separates "positive feelings and positive functioning as key factors for mental health".²⁶⁶ Clinicians readily assert that it is unnecessary to rely on negatively oriented criteria as they highlight an individual's weaknesses. Preference is therefore given to the importance of and strength of personal assets when identifying and treating abnormal behaviour. Iheanacho reports that there are several models of behaviour disorders.²⁶⁷ These

²⁶² *Ibid.*

²⁶³ Gottesfeld, *op. cit.*, pp.11.

²⁶⁴ Marie Jahoda, *Current Concepts of Positive Mental Health* (New York, Basic Books 1958). pp. 47-78.

²⁶⁵ *Ibid.*

²⁶⁶ Silvana Galderisi, Andreas Heinz, Marianne Kastrup, Julian Beezhold, and Norman Sartorius, 'Towards a New Definition of Mental Health' (2015) 14(2) World Psychiatry Journal p.231.

²⁶⁷ Rowland A. Eke Iheanacho, *Reduction to Abnormal Psychology* (Owerri, G. O. C. International Publishers 2002) pp. 56-60.

models of evaluating disordered behaviour include the medical model, the psychoanalytic model, the behavioural model, the cognitive model, the humanistic model, and the socio-cultural model.²⁶⁸

2.1.1. Medical Model

The medical model is the same as the disease or illness model.²⁶⁹ The definitions and terms in the medical model are rooted in medical belief that the root cause of abnormal disorder is found in physically examining the person and may reveal a hormonal imbalance, chemical deficiency and may include brain damage. Some of the major borrowed terms are symptoms, syndromes, illness, hospital, disorders (acute or chronic), or cure.²⁷⁰ Gottesfeld explains that a symptom is a physical or behavioural manifestation of illness.²⁷¹ Definitions of syndromes and the way they connect to disorders have been noted but underutilized in analysing the causes and reasoning especially when an individual ceases to manifest abnormal behaviour.²⁷² Syndrome is a cluster of patterns, which manifests into symptoms for which a particular disease is known; whereas a disorder presents a collection of syndromes possessing common sets of causes or etiology.²⁷³ A disorder becomes acute when it lasts for a brief period and usually considered reversible. On the other hand, a chronic disorder refers to a disorder that is long lasting and cannot be reversed. Alloy, *et al* refers to the medical model as the neuroscience perspective of abnormal behaviour as founded on the analysis of the causes of abnormal behaviour as traceable to the functioning of the

²⁶⁸ *Ibid.*

²⁶⁹ *Ibid.* pp.72-73.

²⁷⁰ *Ibid.*

²⁷¹ Gottesfeld, *op. cit.* p.55.

²⁷² *Ibid.*

²⁷³ *Ibid.*

brain systems and the body.²⁷⁴ It is the oldest perspective of abnormal behaviour, but it is constantly being reviewed as fresh ideas emerge from current scientific research of the activities of the brain and body, especially as the biological basis of behaviour is unveiled with greater precision.²⁷⁵ The authors assert that there is possible interaction between behaviour and organic functions that could result into illness. The genes, the nervous system, the endocrine system then become part of the biological mechanisms that could be investigated to reveal any possible specific pathologies.²⁷⁶ Invariably, this perspective deals with mind-body problem, which is concerned with the relationship between the physical and the psychological issues in the functioning of the individual. There is a positive reactive chain as what affects one, can also affect the other. For example, a stressful job can lead to hypertension; the survivors' immune system in a bereaved family could be altered, rendering them illness-prone.²⁷⁷ On the other hand, altering the body chemistry can have great effects on the emotion and behaviour of the individual. It is highly difficult to separate the physical functioning from the mental functioning. Alloy et al points out that the ground breaking discoveries in medicine especially in the control of infectious illness has provided the leverage for the approach to dominate and impose rules and pattern to abnormal behaviour. Also the breakthrough focused on the ability of the medical model to subdue abnormal behaviour such as madness and present a pattern for treatment. Notwithstanding, the medical model has avoided engaging with the underlying characteristic of an abnormal behaviour rather, there is intense focus on the biological causes.²⁷⁸

²⁷⁴ Alloy, *et al, op. cit.* pp.9-10.

²⁷⁵ *Ibid.*

²⁷⁶ *Ibid.*

²⁷⁷ *Ibid.*

²⁷⁸ Alloy, *et al, op. cit.* pp.10.

Iheanacho notes that one of the criticisms against the medical model is the use of the term “illness”.²⁷⁹ Critics argue that defining illness conceptually would strip people with abnormal behaviour of responsibility for their actions. To the critics, it is improper to absolve people with abnormal behaviour from responsibility for creating such a situation or experience for him or herself.²⁸⁰ The second criticism is that there are a variety of abnormal behaviours that lack traceable organic origin and the possibility of creating “social roles” that are forced on people when they are hospitalised. Such a situation provides a “sick role” people expect them to play.²⁸¹ The next criticism is on the appropriate centres for treating mental disorders because proponents of the medical model tend to regard hospitals and mental health clinics as the only appropriate centres for treating these disorders.²⁸² However, there are several other forms of mental disorders that can be treated with several other forms of therapy without utilising medical treatment. Examples include anxiety, alcoholism, and anorexia nervosa. However, labelling a mental disorder as illness may have an advantage as it reinforces the ideology that relieves the individual from responsibility for the condition and as such reduces the physical trauma the individual may face when perceived as abnormal. Such people are likely to receive humane treatment.

²⁷⁹ Iheanacho, *op. cit.* p.87.

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

²⁸² *Ibid.*

2.1.2. Psychoanalytic Model

Erdelelyi notes that Sigmund Freud developed the psychoanalytic model of analysis on human behaviour.²⁸³ Freud established an interface between thoughtful conscious and unconscious decisions as a model of increasing ones perspective and attaining mind and body dualism.²⁸⁴ However, separating the mental structure from body will resonate with conflicts that represent the outer reality and create the subjective environment to understudy voluntary actions of individuals within a controlled experience.²⁸⁵ These experiences underline the meaning an individual identifies within a structure that can provide function and a structure that alters repression. Understandably, Freud noted that the root of abnormal disorder is traceable to childhood conflicts or experiences with wishes relating to sex and aggression. Freud believes that it is the frustration of the basic biological instincts that can be regarded as the root of all psychopathology.²⁸⁶ The psychic factors and conscious motives are therefore paramount in the development of mental disorders and the tendency to search for organic diseases underserved. Freud believes that children pass through series of stages that involve the impulses of sex and aggression. These ages adopt different forms and stimulate conflicts. Failure to resolve these conflicts successfully causes them to remain buried in the unconscious and eventually leads to behaviour disorders during childhood. Onyejiaku and Onyejiaku view Freud as a strict biological determinist.²⁸⁷ Freud's psychoanalytic theory considers sexuality as influencing human behaviour. Sex and sexual behaviour become an adaptive tool in

²⁸³ Matthew Hugh Erdeleyi, *Psychoanalysis: Freud's Cognitive Psychology* (New York, W H Freeman & Co Ltd 1985). p.2.

²⁸⁴ W.R.D. Fairbairn, *Psychoanalytic Studies of the Personality* (New York, Routledge 1994) p.xi.

²⁸⁵ *Ibid.* pp173-174.

²⁸⁶ *Ibid.*

²⁸⁷ F.O. Onyejiaku, and H.A. Onyejiaku, *Psychology of Adolescence* (Calabar: Excel Publishers 2011) p.42.

the development of the mental and physical structure. This gradual process happens as the individual develops from infancy through several psychosexual stages before arriving adulthood.²⁸⁸ Human infant will therefore be evaluated as consisting of a bundle of sexual drives.²⁸⁹ This model faces with the problem of linking childhood experiences with the abnormal disorder an adult manifests. Iheanacho explains that such consistent underlying unresolved issues make it impossible for the individuals to control their behaviour.²⁹⁰ Another problem concerns the possibility of predicting the future behaviour and outcome of childhood experiences. This is very difficult since the concepts of psychoanalytic model emanated from subjective reports and clinical observations that were not controlled. Invariably, reports and observations cannot be quantified, however, one needs to bear in mind that the primary function of a model lays within its predictive power. The model is also criticized for overemphasising sexual motivation and ignoring the impact and significance of culture within an experience. Psychoanalytic approach to behaviour disorder is very significant as it probes into people's inner life, showing how rich people's inner life involvement can be, and the extent such involvement can significantly influence the individual's later functioning. One advantage of this model is its contribution to the enlargement of ideas about behaviour disorder, and because it is the first alternative to the medical model.²⁹¹

2.1.3 Behavioural Model

The behavioural model rejects the approach of both the medical and the psychoanalytic models. It frowns at the idea that behavioural disorder manifests some

²⁸⁸ *Ibid.*

²⁸⁹ *Ibid.* p.43.

²⁹⁰ Iheanacho, *op. cit.* p.110.

²⁹¹ *Ibid.*

underlying problem (diseases) as propounded by the medical model or some unconscious conflicts, as proposed by the psychoanalytic model. Sarason and Sarason observe that many psychologists viewed Freud's ideas concerning the mind as vague and complicated without the possibility of being tested.²⁹² The theorists consider a better approach of studying the same behaviours with simpler explanation and think of the possibility of *embarking* on an experimental study of behavioural disorders.²⁹³ Sarason and Sarason explain that learning theorists reject the idea that behaviour is of intrapsychic events, but believe it is a product of stimulus-response (S-R) relationship.²⁹⁴ Invariably, to change behaviour, the behaviourists believe in changing the relevant aspects of the environment, especially the sources from which reinforcement could be derived.²⁹⁵ Customarily, behaviourists would utilise the service of reinforcement and punishment. Reinforcement is the procedure that ensures that a response it follows has a high probability of being repeated if it is pleasant or appetitive, or the response is repeated when the procedure is removed or withdrawn if aversive (negative reinforcement). Punishment becomes the procedure that prevents a response from being repeated when it follows the response (presented topic) as it is painful (positive punishment) and increases the tendency to repeat the response when it is withdrawn (omission) when the procedure is pleasant.²⁹⁶ The behavioural model is noted as mechanistic and interested in specific behaviours and unfocused on the total person. In addition, the behavioural model ignores the rich subjective experiences since it is interested only in observable behaviours. Such rich subjective experiences include attitudes, emotions, thoughts, self-awareness and personal values.

²⁹² Sarason and Sarason, *op.cit.*, pp.6-10.

²⁹³ *Ibid.*

²⁹⁴ *Ibid.*

²⁹⁵ *Ibid.*

²⁹⁶ *Ibid.*

2.1.4 Cognitive Model

The cognitive model rejects the ideas or the submission of the medical, psychoanalytic, and behavioural models and states that people's behavioural disorders cannot be seen to be a circumstance beyond their immediate comprehension or control. The model supports the belief that the causes of behaviour disorder are extended; however, they are not factors beyond the control or dominance of the individual. It recognises the cognitive ability of the individual to dissect emotions and comprehend realities (the beliefs and thoughts of the individual). Iheanacho reports that faulty thinking habit is what is responsible for behaviour disorders.²⁹⁷ When a person becomes highly pessimistic or catastrophic in thinking, behaviour disorder may be the eventual outcome.²⁹⁸ Sarason and Sarason explain that the model views the human being as an information processor and problem solver by studying and analysing the way the individual attends, interprets and uses the information at his disposal.²⁹⁹ The model is interested in how people interact with their environment, acquire and interpret information, which they utilise in problem solving. It ignores hidden motivation, feeling and conflicts but focuses on mental processes people are aware of, including the ones they can easily be made aware of. As information processors, people are engaging in continuous gathering, storing, modifying, interpreting and understanding internally generated information as well as information from the environment.³⁰⁰ The cognitive theorists view mental life as consisting of schemata that contain how people process information to enable them select strategies

²⁹⁷ Rowland A. Eke Iheanacho, *Introduction to Abnormal Psychology* (Owerri, GOC International Publishers 2002).p.16-17.

²⁹⁸ *Ibid.*

²⁹⁹ Sarason and Sarason, *op. cit.*, pp.70-72.

³⁰⁰ *Ibid.*

to help them solve problems or attain a particular goal. Self-schemata contain relevant information to the individual and such information includes emotions that can possibly distort perceptions of what constitutes reality.³⁰¹ One problem with the cognitive model is its dependence on inferences, which is not scientific and therefore difficult to qualify the strength of interactions and outcomes.³⁰² Secondly, cognitive model has the history of changing what it hypothesised to be central to its theory continuously. A major criticism concerning their therapy is whether it is central and balanced for individual expectations. Critics believe that changing a person's way of thinking about the world does not always provide all the answers and may not be appropriate.³⁰³

2.1.5 Socio-Cultural Model

Socio-cultural model is concerned with how behaviour is influenced by several factors. Consideration is therefore given to the product of broad social forces. Indicative patterns reveal that the starting place for socio-cultural model lies in the social determinants of behaviour or how the social environment and other people influence behaviour.³⁰⁴ Powerful situational forces, such as social pressure on people to conform to social rules can cause unsuspecting people to believe in extreme ways others might label as "mentally ill", or "immoral".³⁰⁵ It is possible to induce many normal people to cause unimaginable injury to others once directed by an approved authority. Alloy, *et al* further asserts that individuals should not be totally blamed for

³⁰¹ *Ibid.*

³⁰² Alloy, *et al*, *op. cit.* p.141

³⁰³ *Ibid.*

³⁰⁴ *Ibid.* pp.142 -145.

³⁰⁵ *Ibid.*

their extreme behaviours, but on powerful situational forces.³⁰⁶ Problems within the individual cannot account for all the individual's behaviour. Powerful situational forces such as racism, poverty, as well as being labelled mentally ill can induce one into intense social adversity and stress and can lead to behavioural disorder. Iheanacho adds that the type of family group, society, shapes behavioural disorder and culture the individual finds himself.³⁰⁷ The pattern of relationships existing between an individual and others could support or cause behavioural disorder such as anorexia nervosa. This means that the kinds of stresses and conflicts people experience in their daily interactions with their neighbours in their environment can promote behavioural disorders. The position has statistical support. The number of people with a particular type of disorder found in a particular socio-economic class out-numbers the others. Observations also show that periods of poor economy tend to be associated with declining psychological functioning and social problems.³⁰⁸ According to Sarason and Sarason, individuals with anorexia nervosa tend to be increasing in numbers probably because of socio-cultural pressures.³⁰⁹ For instance, the body weight the society regards as ideal for women has recently decreased. Researchers have found the average hip and bust measurements of models in "playboy" magazine centrefolds have decreased for the past 20 years.³¹⁰ However, there is a discrepancy between the ideal and reality, which increased as the average weight of American women decreased by 5 pounds for those who are under 30. Such cultural pressure is also noticeable among occupational groups that tend to desire thinness a great deal. So anorexia nervosa is more likely to be found among female

³⁰⁶ *Ibid.*

³⁰⁷ Rowland. A. Eke Iheanacho, *Introduction to Abnormal Psychology* (Owerri, GOC International Publishers 2002) p.64.

³⁰⁸ *Ibid.*

³⁰⁹ Sarason and Sarason, *op. cit.* p.192.

³¹⁰ Martin Voracek and Maryanne L Fisher, 'Shapely Centrefolds? Temporal Change in Body Measures: Trend Analysis' (2002) 325(7378) British Medical Journal. pp.1447-1448.

ballet dancers and models when compared with other women of their age. When the competition in ballet schools increases, the probability of these ballet dancers becoming anorexic increases.³¹¹

The class system is more aligned with western ideals of thinness.³¹² Internalisation of the ideal thinness is established as a potent factor in western development of anorexia; however further analysis reveals a core influence of socio-cultural factors in eating attitudes especially in developing countries.³¹³ The reason for these differences can be traced to the lifestyle, expectations and opportunities among the classes. People's cultural biases may be the reason why they ascribe disorders to different social classes. What people might observe among the wealthy and term as amusing could be labelled a disorder when observed among the poor. Understandably, class and culture play a significant role and to a great extent determine what constitutes mental illness. Janda and Klenke-Hamel explain that behavioural disorder can only be determined within a societal context.³¹⁴ The rules stipulating the norms for appropriate and inappropriate types of behaviour abound in every society, with their appropriate sanctions for violation. Therefore, behaviours that adhere to societal norms are normal while the others are disorders.

³¹¹ Anna L. Wonderlich, Diann M. Ackard and Judith B. Henderson, 'Childhood Beauty Pageant Contestants: Associations with Adult Disordered Eating and Mental Health' (2005) 13(3) *Eating Disorders Journal*. pp.291-301.

³¹² Jillon S. Vander Wal, Judith L. Gibbons and Maria del P. Grazioso, 'The Sociocultural Model of Eating Disorder Development: Application to a Guatemalan Sample' (2008) 9(3) *Eating Behaviour Journal*. pp.277-284.

³¹³ *Ibid.*

³¹⁴ L. H. Janda Klenke-Hamel, *Psychology: Its Study and Uses* (New York, St. Martins 1982). p.44

2.2 Body Image and Self-Satisfaction

Research reveals that people attribute the quest for self-satisfaction and positive body image to various reasons. It is well pronounced within the study that the fear of weight gain is a predominant factor in individuals with unusual eating patterns. However, consideration should be given to the thought that desires to lose weight, become thin or remain thin constitute the outcome of the process of redefining body image criteria and satisfaction. Santrock explains that it is the fear of becoming fat that leads to the adolescents' desire to become thin or lose weight. The fear does not decrease even when there is weight loss, which should fulfil the end result of developing anorexia nervosa. Considering that anorexia nervosa is the outcome of a weight loss that is less than 95 percent of the individual's normal weight, there is the tendency for the person to have a distorted image of the body and shape. The perception of the individual as not being thin enough, especially in the abdomen, buttocks and thigh and the tendency to weigh the body regularly and take critical observation of their body in the mirror becomes actions that signify dissatisfaction. Other indicative actions include tape measurements and critical observation of body in the mirror as a form of evaluation of body through the purview of being satisfactory or not.³¹⁵ The tendency to include body image in self-evaluation is virtually non-existent when maturing youths start evaluating themselves in terms of personal abilities achievement and contributions in their areas of specialisation. It is virtually impossible to overlook the importance of body image in the self-concept of a person at any point in their life. However, it is during adolescence that self-concept assumes the greatest pre-eminence.

³¹⁵ John W. Santrock, *Adolescence* (Boston, McGraw-Hill Publishers 2005). p.533.

Clinicians through the lens of what constitutes body image disturbances, evaluate the manifestation of anorexia nervosa.³¹⁶ Body dissatisfaction is therefore ultimately aligned with abnormality and neurological impairment conforming to the medical model.³¹⁷ Body image is conceived “as the neutral representation determining bodily experience, the mental image that one has of his body, as the feeling one has about his body and a personality construct.”³¹⁸ Onyejiaku and Onyejiaku note that body image concerns are more evident in female especially as they transition from puberty to adolescent.³¹⁹ Body modification is therefore common and precipitates self-concept in terms of exerting control on who they are and how they are perceived.³²⁰ For instance, the marital value of a lady in Nigeria accrues not only as a self-construct, but also the body image construction of suitors often base their choice of a girl on her height, weight and facial appearance, complexion, and body proportion.³²¹ Such emphasis is lacking amongst the male gender. The female body becomes the object and subject of both negative and positive construction by conforming to socio-cultural narratives of self-construction. At this stage, the control of female body is dissected into three parts – principally, the version the individual identifies with, the part the society can acknowledge and dominant male gendered perspective. Body image disturbances can only become apparent to self-constructed individual when there is a disparity in bodily objectives or a compromise in bodily integrity. Adolescents believe the satisfactory body size and shape is evaluated by physical characteristics and hence that determines how they value themselves.³²² The general body build, height in

³¹⁶ D.M. Garner and P.E. Garfinkel, ‘Body Image in Anorexia Nervosa: Measurement Theory and Clinical Implication’ (1981) 11(3) *International Journal of Psychiatry in Medicine* pp. 263-265.

³¹⁷ *Ibid.*

³¹⁸ *Ibid.*

³¹⁹ Onyejiaku and Onyejiaku, *op. cit.* p.69

³²⁰ *Ibid.*

³²¹ *Ibid.*

³²² *Ibid.*

particular, is what influences how the adolescents perceive themselves. These adolescents evaluate their bodies in comparison to some ideal concepts that prevail in a particular society. Some stereotypes are prevalent in some societies, the age, sex or ethnic background notwithstanding. One would not be surprised to learn that most adolescents spend much of their time in front of mirrors examining their physique. The reason for this kind of self-examination could be to identify some stereotypes to help them recognise how they look in reality and the ideal they wish to attain. The self-evaluation is in terms of weight, height, and general body configuration and how they appear facially. Consequently, the physical appearance becomes of great importance to these adolescents and young women.

However, the details of gendered gratification are gradually fading due to the changing social and economic realities; men are becoming more concerned with the abilities and achievement of women. Regardless, the value placed on the way the female body changes and develops is still sustained across all background. Understandably, with the emergence of body positive movements, there is obvious or pronounced consideration to dissecting the female physique in terms of facial appearance, height, weight and body proportions which contribute to the girl's personal attractiveness. Prominence is given to the lesser antagonising narrative of presenting a well-grounded girl whose intellectual excellence combines with her attractive physique and such a girl is assured not only of marriage prospects but also of economic independence. External pressures to conform to particular body type are ever present and can lead to distorted self-perception, which may lead young women to make decisions to constantly alter or modify their bodies as they develop. This may happen even when she is growing normally and may achieve a physical body considered above average in the society. At this stage, behavioural changes may be

observed and emotional instability prominent as feelings of dejection; alienation, isolation and emotional disturbance begin to emerge. Self-doubt resonates as part of their experience and may be aggravated by existing prevalent socio-personal problems, such as relationship with others, particularly the opposite sex. Every aspect of the experience is crucial to self-evaluation and body image construction. Individualised perspectives are dominant and often play a significant role in sorting out both aspects of physical and mental impact and invariably there would be significant differences in perspectives and outcomes.

Onyejiaku and Onyejiaku view self-concept as an on-going process, involving the totality of a person's transactions with the world. It is the embodiment of their collective experiences from childhood, adolescence and then adulthood.³²³ At every stage, an action creates either negative or positive impacts in the person's self-esteem or value and the new meaning the person assigns to the body and self will slowly emerge. In the adolescence stage, negative and positives are assigned meaning and therefore able to interpret any physical factors that might be negative as adequate. Such an interpretation will be tempered by the person's concept of herself.³²⁴ This implies that when a person enters adolescence with a feeling of inadequacy, they are more than likely to view their body as not what he or she desired it to be, even though others may view them as adequate.³²⁵ Santrock reports the common problem both boys and girls experience in adolescence which is the core of where their identity is first developed. Adolescents develop individual images of their bodies in puberty and are preoccupied with body perceptions.³²⁶ The adolescents' preoccupation with the image of their bodies is very strong at this particular period of development. This

³²³ Onyejiaku and Onyejiaku, *op. cit.* pp.81-92

³²⁴ *Ibid.*

³²⁵ *Ibid.*

³²⁶ Santrock, *op. cit.* pp. 29-30

concern is most acute during puberty.³²⁷ The adolescent is observed to be examining him or herself to possibly detect any thing not acceptable on his or her body. However, there are differences between the boys and the girls in their perception of their bodies.³²⁸ The reason for this is traceable to the increases in body fat. However, the opposite is the case with the boys, who become more satisfied in their movement through puberty.³²⁹ This is probably because of the increase of their muscle mass. Women appear to be less happy with their bodies generally; however, there is tendency to have more negative impression of their body images throughout puberty.³³⁰ What tends to be of immediate concern to the adolescent girls is their motivation to be very thin. In the western society, the motivation to be thin is seen as mainly because of the media equating beauty with extremely thin figure. Media impact has become dominant within the narratives of body constructs although not accepted as part of the reasoning underlining body constructs. This type of image projections contribute to body image concerns and, to other extents, the development of disordered behaviour.³³¹ The media acceptance of the thin image as desirable extends beyond the confines of the fashion industry and can be viewed within social contexts where eating disorders can be evaluated within the reoccurring normative body discontent. Accordingly, Spettigue and Henderson note that “magazines, articles, television shows and advertisement have also created a social context that may contribute to body dissatisfaction and disordered eating in girls.”³³² Multiple evidence of media exposure of adolescent girls reveals social pressure to adhere to

³²⁷ *Ibid.*

³²⁸ *Ibid.*

³²⁹ *Ibid.*

³³⁰ *Ibid.* pp.169-182.

³³¹ *Ibid.*

³³² Wendy Spettigue and Katherine A. Henderson ‘Eating Disorders and the Role of the Media’ (2004) 13(1) Canadian Child and Adolescent Psychiatry Review available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2533817/> [accessed 19th April 2018] pp.16-19.

social comparison of body dimensions. A finite line is however drawn when these women develop a framework for interpreting media induced messages.³³³ Comparatively, the male gender exhibits a different behavioural pattern regardless of media impression. To show how adolescents value their body images, boys tend to say to each other in conversation, the characteristics of their physical features. Regarding the adolescent girls, in any introduction, what follow after their names were their description of their hair, such as having long blond hair, their height such as being 5 feet 5 inches tall, and their weight such as being 110 pounds. The adolescent boys tend to follow this trend by stating their names followed by description of their physical features without necessarily displaying either negative or positive body dissatisfaction. This is an extreme standard of thinness too difficult a body weight ideal for most of the people to achieve, if not impossible.³³⁴ However, some women report they have a body weight ideal that are lower than both the average weight and what is even lower than can attract men. Both male and female models tend to be moving towards unrealistically thin images in the fashion pages.³³⁵ Both genders exist within the same mass media impression, yet they produce different outcomes in behavioural patterns and in the development of body dissatisfaction. Can we then rely on media imprints as justification for behavioural changes, body image distortion or self-starvation? Although Spettigue and Henderson project an indisputable presence and influence of social cultural pressures,³³⁶ however underling this message is the portrayal of the female gender as easily influenced, disempowered

³³³ *Ibid.*

³³⁴ *Ibid.*

³³⁵ *Ibid.*

³³⁶ *Ibid.*

and lacking in control and personal will power consistent with prevalent gender role endorsement gratifying masculinity over femininity in eating behaviours.³³⁷

Deliens, *et al* examine the factors, which influence Belgian university students' eating behaviour. Their preferred design was the qualitative research design.³³⁸ The purpose of their research was to collect ideas and recommendations that would aid their development of effective intervention programmes aimed at improving healthy eating behaviours in the study participants. Semi-structured questionnaires and focus group discussion were employed in obtaining data. Data collected were analysed and result of analysis revealed different reasons for students' choices of healthful foods.³³⁹ Reasons put forth by the subjects among others included self-discipline, time aid convenience. In the researchers view, one of the factors that determine or promote self-discipline is the desire of the individual to maintain a beautiful body structure in the eyes of those who are conscious of their body size (such as the anorexics) and define good body size as thinness.³⁴⁰ Eating healthful foods means taking a bite of the food and maintaining high degree of starvation; taking control of what to eat, what not to eat and the quantity to ingest at any point in time.³⁴¹ This is done irrespective of the nutritional needs of the body to promote growth, development and general wellbeing. Further research equally reveals that individuals with or without eating disorders differ notably in terms of their perceived causes of body dissatisfaction.³⁴² The study

³³⁷ Eric Stice, Erika Schupak-Neuberg, Heather E. Shaw and Richard I. Stein 'Relation of Media Exposure to Eating Disorder Symptomatology: An Examination of Mediating Mechanisms' (1994) 103(4) *Journal of Abnormal Psychology* pp.836-840.

³³⁸ Tom Deliens, Peter Clarys, Ilse De Bourdeauhuij and Benedicte Deforche 'Determinants of Eating Behaviour in University Students: A Qualitative Study Using Focus Group Discussions' (2014) 14(3) *BMC Public Health* pp. 2-12.

³³⁹ *Ibid.*

³⁴⁰ *Ibid.*

³⁴¹ *Ibid.*

³⁴² *ibid.*

by Salafia, *et al* on the differences between the perceptions of the cause of disordered eating in individuals with eating disorders and those without,³⁴³ reveal that individuals without eating disorders tended to overly attribute the problem of eating disorders to media.³⁴⁴ The overall impression by non-disordered individuals is that the media create false impressions on perfect physical looks and beauty which gives rise to the negative cognitions that leads the anorexics to self-starve and subsequently develop mental health issues.³⁴⁵ On the part of those with eating disorders, the researchers observe that they emphasised less on media as a factor in eating disorders. Rather, they evenly attribute the underlying cause to psychological, emotional and social problems.³⁴⁶ Equally played down are the roles of genetics/biology as well as media/culture ideals in causing eating disorders. Downplaying the media's role may arise from not being fully aware of the influence of media on developing cognitions that lead to manifesting anorexia nervosa overtime. The acknowledgement by Salafia *et al* that individuals begin to form their perceptions of body attractiveness, health acceptability and functionality during childhood give credence to possible code for the underlying substructures of eating disorder.³⁴⁷ Furthermore, the authors note that the view about body image is reinforced as individual's age through feedbacks from peers, family members and other significant persons in their lives. Feedbacks such as this encourage the anorexics to indulge in self-starvation and the maintenance of the anorexic body. The situation explained here is prominent in western societies where extreme thinness is seen as a yardstick for measuring beauty.³⁴⁸ Given the stages of

³⁴³ Elizabeth H. Blodgett Salafia, Maegan E. Jones, Emily C. Hougen and Mallary K. Schaefer, 'Perceptions of the Causes of Eating Disorders: A Comparison of Individuals with and without Eating Disorders' (2015) 3(32) *Journal of Eating Disorders* available at <https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-015-0069-8> [accessed 17th April 2019].

³⁴⁴ *Ibid.*

³⁴⁵ *Ibid.*

³⁴⁶ *Ibid.*

³⁴⁷ *Ibid.*

³⁴⁸ *Ibid.*

physical transformation to adulthood, positive body image indication may not be immediately apparent. Santrock reports that if girls feel negative about their bodies when they were in their early adolescence, they were more likely to develop eating disorders two years earlier than the adolescents who had no negative feeling concerning their bodies.³⁴⁹ When girls have positive relationships with their parents, such girls tend to have healthier eating habits than the girls who have negative relationship with one or both parents. Adolescents who have negative relationship with their parents tend to be involved in increased dieting for a period of one year, for the girls.³⁵⁰ The girls that were sexually active in pubertal transition and with their boyfriends tend to be involved in dieting or engaging in disordered eating pattern.

Shaffer and Kipp explain the effects of body image on identity formation.³⁵¹ As the body of adolescents begin to mature into adult men and women, the way they feel about this development is noted as contributing to their identity development.³⁵² When an adolescent has positive feeling concerning his or her body, especially the appearance of that body, he or she tends to have high self-esteem and positive peer relationship.³⁵³ Conversely, when an adolescent is dissatisfied with his or her body and decides to focus on its shortcoming, in comparison to unrealistic culture as well as social ideals of attractiveness, he or she may experience depression and may also engage in unhealthy weight control behaviour. Body image dissatisfaction arising from the discrepancy between how a teen assessed his or her physical appearance and that teen's internal picture of what is considered ideal body has emerged as what strongly predicts the adolescent's depression. Measurements of how the body image

³⁴⁹ Santrock, *op. cit.* pp.532-535

³⁵⁰ *Ibid.*

³⁵¹ David R. Shaffer and Katharine Kipp, *Developmental Psychology: Childhood and Adolescence* (7th edn Lingage Learning Wadsworth 2010) pp. 46-66.

³⁵² *Ibid.*

³⁵³ *Ibid.*

dissatisfaction is derived are subjective. This adolescent's individualised body image refers to what the adolescent believes he or she looks like, while the ideal body image refers to what the adolescent conceptualised as the perfect body.

These two types of body image are derived from the belief of the adolescent concerning appearance and how important it is to his or her life. Adolescent girls are more unified in their goals regarding what to feel concerning their body image dissatisfaction especially a voluntary choice of becoming thin. Many girls become dissatisfied with their body image as their weight increases. It is only very few adolescent girls that express satisfaction with their bodies. Eating behaviours are gradually readjusted, as the individual gets older. Most critically, the way the individual evaluates himself or herself in terms of physical characteristics decreases, as the person gets older. Actions that address body image dissatisfaction become less of an impression but a voluntary action requiring careful planning and execution. The actions that fulfil the fear of weight gain also fulfil the individual's ideology of what constitutes their bodily integrity.

2.3 Underlying Substructures

Underlying substructures of anorexics reveal the reasoning behind self-starvation. The desired weight loss is achieved through self-induced voluntary actions of food refusal, restriction, starvation and exercise. Ordinarily embarking on physical and strenuous activities to burn calories can be seen as voluntary action as they are premeditated and carefully planned out so a certain level of competence are present. Clinicians, however, argue otherwise stating that activities burning calories and maintaining the anorexic body of extreme thinness is a major priority for the anorexic and due to an

already compromised mental state, fulfilling their mission is inevitable. Invariably the actions of the anorexic body with regards to eating habits and excessive exercise can be viewed as unhealthy and carrying weighty consequences. In other words, the consequences of attaining the anorexic body are grave and cannot be accounted for by mentally stable individuals. As previously noted, exhaustion which results from poor intake and excessive activities, irregularities such as loss of menstruation, constipation, abdominal pain, acid reflux, irregular heart rhythm, low blood pressure, dehydration and inability to sleep also referred to as amnesia are all consequences that might arise from anorexia nervosa.³⁵⁴ Furthermore, anorexia nervosa has been associated with serious emotional and physical problems which impact on the anorexics ability to function effectively. The anorexics' determination to maintain a thin body, which leads to self-starvation and extreme exercise, is linked to childhood experiences, which are either emotionally or physically traumatising. Clinicians argue that these childhood experiences often go unaccounted for and later resurface during the preliminary year of the development of anorexia. Underlying mental imbalance is also recognisable in the inability of the patient to effectively carry out their day-to-day activities as well as function maximally using their full potentials. This condition in the end may result in the anorexic becoming miserable which subsequently would lead to the manifestation other mental health issues such as obsessive-compulsive behaviour, borderline personality disorder as well as anxiety

Davenport, *et al* posit that those who suffer from anorexia nervosa exhibit dysfunctional cognitive processes.³⁵⁵ The research revealed that both typical and atypical anorexics differed in their expression and manifestation of dysfunctional

³⁵⁴ Alloy, *op. cit.* p.81.

³⁵⁵ Emily Davenport, Nola Rushford, Siew Soon and Cressida McDermott, 'Dysfunctional Metacognition and Drive for Thinness in Typical and Atypical Anorexia Nervosa' (2015) 3(24) Journal of Eating Disorder pp.1-2.

metacognition and drive for thinness.³⁵⁶ Their study reveals that as both the typical and atypical anorexics engage more and more in self-starvation, food refusal and excessive exercise, so do they develop distorted and complex metacognitions and destructive emotions. Subsequently, they begin to act in ways that may be harmful to them as well as others around them, relating dysfunctional metacognition personality disorder.³⁵⁷ Sun, *et al* support the view that dysfunctional metacognition are common processes across pathologies. They however point out that certain dimensions of these dysfunctions were more prevalent in particular disorders than others.³⁵⁸ The literature reveal that as individuals' cognitions become distorted, so would they become unable to act rationally and indulge in behaviours or take actions that could harm them further psychologically and physically.³⁵⁹

The commonalties of other noted mental disorders in women with full-blown eating disorders is a direct indication that they could be precipitating factors which are not consequences of food refusal. Genetic predisposition to anorexia nervosa is hardly acknowledged even though it is now known that it could run within families.³⁶⁰ The treatment of anorexia nervosa and anorexia itself may be complicated due to the psychopathological aspects of obsessive-compulsive disorder that also implicates neuroendocrine mechanism. Personality characteristics and family interaction patterns are seen as contributing to the development of anorexia nervosa. Some other characteristics of the girls with anorexia include that they feel a lack of control, and at the same time have a need for approval³⁶¹. Anorexics also have a need to exhibit a

³⁵⁶ *Ibid.*

³⁵⁷ *Ibid.*

³⁵⁸ X. Sun, C Zhu and S.H.W. So, 'Dysfunctional Metacognition across Psychopathologies: A Meta-Analytic Review' (2017) 45 European Psychiatry Journal pp.139-153.

³⁵⁹ *Ibid.*

³⁶⁰ *Ibid.*

³⁶¹ *Ibid.*

behaviour that is contentious and perfectionistic because of the experience of body image distortions, even though it is not clear whether this distortion is a cause of the disorder or its consequence. This could be noticed whether these girls still feel they are overweight when they have actually lost a great deal of their weight. Not to mention that family patterns are embedded as women with anorexia nervosa tend to come from families where psychopathology or alcoholism or even from families that is very close to each other but lack good means of communication in terms of emotion, or in conflict resolution.³⁶² Behavioural adjustments are emulated by mothers who tend to have eating disorders themselves, as well as being dissatisfied with their daughters' appearance and also dissatisfied with their families dynamics. Therefore, in such cases, there is a possible link between the disordered eating and the mother and daughter relationship. Issues of personal identity and autonomy can lead to anorexia nervosa when they are introduced during puberty. Direct confrontation is not as important as with the conflicts of need to separate from family and the need to assert oneself in social situations precipitating anorexia, a self- destructive response. Gleitman however opines that there is no known organic pathology that produces anorexia nervosa; notwithstanding, there are some psychological factors that can present an underlying substructure.³⁶³ Apart from strenuous exercise that lasts for several hours a day, many authors believe that anorexia is primarily caused by psychological factors and the concern on food, not eating the food due to modern obsession with becoming slim. In another dimension, anorexia nervosa is viewed as caused in some cases by the person's fear of becoming sexually unattractive or even of sex. Some people may focus mainly on rebellion against their parents. To some others, the focus may be strongly on desire to have some degree of autonomy and

³⁶² *Ibid.*

³⁶³ Henry Gleitman, Gross James and Daniel Reisberg, *Psychology* (New York, WW. Norton & Company 2010). p.728.

control over their body. From the reports so far reviewed, it is obvious that both biological and psychological factors could be responsible for eating disorder.

There is no single thermostat for hunger; however there is need to consider the function of the hypothalamus in the brain as an important factor because it regulates such motives as the sex, thirst and hunger drive.³⁶⁴ From the signals from the sugar level in the blood and neural messages from the liver and the stomach, one is able to determine when there is hunger. There is a part of the hypothalamus that acts as a feeding system, which is responsible for initiating eating.³⁶⁵ When this lateral hypothalamus is deactivated with the services of an electrified probe, any animal that is involved will start eating immediately, whether it is fully fed or not. Unfortunately, when this side of the hypothalamus is destroyed, it may cause the animal never to eat again in life. There are several ways to “turn on” this lateral hypothalamus.³⁶⁶ During hunger strikes, the stomach lining produces ghrelin, which is a hormone responsible for activating the lateral hypothalamus. There is second part of the hypothalamus associated with the satiety system, otherwise known as the “stop mechanism” for eating. Coon and Mitterer further report that when this ventromedial hypothalamus becomes damaged, what follows is dramatic overacting. Another means to stop eating is through the intervention of the chemical called glucagon like peptide I (GLP-I), which is increased by the intestine when food is eaten.³⁶⁷ The arrival of enough of this GLP-I from the intestine causes desire for food to cease. It should be noted that the GLP-I travels to the brain from the intestine, through the bloodstream. It should also be noted that the hypothalamus takes at least 10 minutes to respond after eating has started. This becomes advantageous for those who eat slowly as the brain gets alerted

³⁶⁴ Coon and Mitterer, *op. cit.* pp.382-384.

³⁶⁵ *Ibid.*

³⁶⁶ *Ibid.*

³⁶⁷ *Ibid.*

that you have eaten enough before you overeat.³⁶⁸ Another part of the hypothalamus that affects hunger is the periventricular nucleus. It controls the blood sugar level ensuring it is steady. It does so as it starts and stops eating. The periventricular nucleus is sensitive to another substance by name the neuropeptide (NPV), large amount of which causes the animal to keep eating until it becomes impossible to hold another bite.³⁶⁹ In addition, it is known that hypothalamus can also respond to a chemical in marijuana. This substance is capable of producing intense hunger. Another function of the brain is to control the weight over a long period, beside regulating when to start and stop eating.³⁷⁰

Defining anorexia as a diet or fad creates the narrative of myth and invalidates the long-term goal, reasoning and meaning underlying weight loss, thus removing accountability and responsibility from both the clinician and the individual. Although there is a significant obsession with weight loss, individuals who engage with disordered patterns of eating commonly admit the much-needed interest in losing weight goes beyond temporary gratification. This is evident in most cases of female adolescents who are still constantly obsessed with their desire to lose weight regardless of how emaciated and thin they are. Researchers and clinical experts explore complex biological, environmental and societal reasons whilst adhering to the strict guidelines provided by the Eating Disorder American Psychiatric Association. Understanding these biosocial cultural factors are relevant but clinicians treat each underlying reason and cause as the same. The biological, genetic and environment factors are analysed within a specific spectrum; however, it has noted that every case is different and the factors that are relevant in one case might be irrelevant in another.

³⁶⁸ *Ibid.*

³⁶⁹ *Ibid.*

³⁷⁰ *Ibid.*

Clinical criteria frame the anorexic body as emaciated, frail and severely underweight females, lose significantly their weight below normal, which may be about 15 percent or more.³⁷¹ This is also substantiated by media portrayal, however it has been noted that most individuals with eating disorders are not physically thin or underweight.

2.4 Disordered Eating and Obesity

There are variations of feeding disturbances, which may include severe forms of eating or overeating. Coon and Mitterer therefore notes that "...eating and over eating are related to internal and external influences, diet, emotions, genetics, exercise and many other factors."³⁷² Volkow et al notes that persons who are more than 20 percent beyond the ideal body weight, as various mortality studies have indicated, are classified as obese.³⁷³ An obese status is validity using the body mass index system to calculate the ratio of body weight to height. Obesity, "body mass index ≥ 30 ", represents the other end of weight spectrum in disordered eating and abnormal feeding behaviours.³⁷⁴ Life expectancy is greatly reduced, as the individual is susceptible to cancer, heart diseases and diabetes.³⁷⁵ Like other disordered behaviours, obesity presents a multifaceted problem that requires a multilevel approach to understand the reasoning and meaning. Methods implored can extend to examining behaviour, cognition (how one thinks about food and obesity), underlying biology and the societal context where cheap and tasty food is always available. It is necessary to note that there is a linkage among genetic predispositions, feelings,

³⁷¹ *Ibid.*

³⁷² Coon and Mitterer, *op. cit.* p.328.

³⁷³ Nora D. Volkow and Charles .P. O'Brien, 'Issues for DSM-V: Should Obesity Be Included as a Brain Disorder?' (2007) available at <https://ajp.psychiatryonline.org/doi/full/10.1176/ajp.2007.164.5.708> [accessed 4th August 2019].

³⁷⁴ *Ibid.*

³⁷⁵ *Ibid.*

thoughts and behaviour including the loop through which these variables cycle, which is continuous. Body dissatisfaction and body image distortion is a common occurrence as the individual moves from adolescent to adulthood. Voluntary and uncontrolled patterns of binge eating are connected to emotional and psychological factors. According to Leme, *et al*:

“....disordered eating behaviours and attitudes are part of the eating disorders continuum and include obsessively thinking about food and calories, becoming angry when hungry, being unable to select what to eat, seeking food to compensate for psychological problems....”³⁷⁶

Psychological problems encountered because of the extreme stigma which obesity attracts are rather prominent; however medical issues remain prioritised. The obese are seen as being less attractive, less intelligent, less productive and less socially adept, when compared with those who are not overweight. Equally notable is the fact that a linkage exists between self-perception as overweight and the problems of anxiety, low self-esteem and depression. There is also a socio economic implication and understanding that once a person becomes fat, less food is required to maintain that weight than was needed to attain it. This is because fat has a lower metabolic rate as it takes less food energy to maintain, when compared with other tissues. The body of an obese tends to maintain body weight within a higher-than-average range. If the weight drops below this range, which is called the “set point or settling point”, hunger

³⁷⁶ Ana C.B. Leme, Debbie Thompson, Karin L.L. Dunker, Theresa Nicklas, Sonia T. Philippi, Tabbetha Lopez, Lydi-Anne Vezina-Im, and Tom Baranowski, ‘Obesity and Eating Disorders in Integrative Prevention Programmes for Adolescents: Protocol for a Systematic Review and Meta-analysis’ (2018) 8(4) BMJ Open available at <https://bmjopen.bmj.com/content/8/4/e020381> [accessed 10th December 2018].

increases for the person while the metabolism decreases.³⁷⁷ The body, therefore, adapts to starvation as it now burns off fewer calories and reduces extra calories by burning off more.³⁷⁸ Furthermore, this could explain why the quantity of food that was enough to maintain weight before a diet started may even increase at the end of the diet. The body may still be conserving energy. Obesity can be socially toxic, as it could affect how one is treated and how one feels about oneself. People know the stereotype, which include being sloppy, lazy and slow. The stereotype of the obese also extends to their personality, as people tend to rate them as being very mean, more obnoxious, less friendly and insincere. Body image concern is heightened by societal negative attitude towards the obese, which furthers stigmatization. This attitude forms part of the motivation for prejudiced and discriminatory attitude against the obese.

Pingitore, *et al* reveal the extent of weight discrimination in a videotaped mock job interview involving professional actors who acted as normal weight or overweight (by wearing some gadgets that made them look 50 pounds heavier). Body image stereotype was consistent throughout the experiment process.³⁷⁹ The talent of the actors were less significant and focus was their body proportion and how less attractive they were. When an overweight individual appeared for the interview using same lines, intonations and gestures, he was rated as being less worthy to be hired. Such weight bias was very pronounced against women applicants.³⁸⁰ Weight discrimination, which is not usually discussed, is greater than gender and race discrimination, occurring at every stage in the cycle of employment. It could be at the stage of hiring, placement, promoting or compensating the person, and even

³⁷⁷ Gazzaniga, *op. cit.* p.31.

³⁷⁸ David G. Myers, *Exploring Psychology* (New York, Worth Publishers 2008), p.347.

³⁷⁹ R. Pingitore, B.L. Dugoni, R.S. Tindale and B. Spring, 'Bias against Overweight Job Applicants in Simulated Employment Interview' (1994) 79(6) *Journal of Applied Psychology* pp.909-917.

³⁸⁰ *Ibid.*

disciplining or discharging the employee.³⁸¹ Pingitore, *et al* note that “the stereotype that the obese are emotionally impaired, lazy, selfish might be expected to lead to employment discrimination. Myers also adds that bias also exists in families where children whose parents are overweight prefer to conceal the identity of their parents and not engage with them in public.”³⁸²

Gazzaniga, *et al* report that being overweight is associated with lower socio-economic status in industrialized countries, notwithstanding the abundance of food especially in the case of women.³⁸³ However, some cultures do not stigmatize obesity. Many in some developing countries, particularly Africa, regard those who are obese as belonging to the upper socio-economic class.³⁸⁴ Obesity can equally be seen as a status symbol in these developing countries, which is an indication, that such people have enough income to feed luxuriously.³⁸⁵ In western culture, emphasis on food restriction is less pronounced although there is emphasis on both the cultural and physical circumstances surrounding feeding. The role of the law in managing and treating obesity is different. The “law has the power to control commercial food practices, to regulate physical and economic environments, to regulate media practices, and support informed consent by requiring the provision of information”.³⁸⁶ The law here does not seek to coerce or force the obese to stop eating as a life-saving treatment. However, there is an element of indirectly regulating obese behaviour by overseeing “influences on food choices, and using law in support of strategies to

³⁸¹ *Ibid.*

³⁸² *Ibid.*

³⁸³ Gazzaniga, *et al. op. cit.*, p.447

³⁸⁴ *Ibid.*

³⁸⁵ *Ibid.*

³⁸⁶ Robyn Martin, ‘The Role of Law in the Control of Obesity in England: Looking at the Contribution of Law to a Healthy Food Culture’ (2008) 5(21) Australia New Zealand Health Policy available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2615029/> [accessed 6th March 2018].

redirect food choices towards healthy food products”.³⁸⁷ This approach enables the obese to retain their freedom, autonomy and right to continue food consumption or not. Structural similarities between anorexia nervosa and obesity are far in-between. Interestingly, suggested solutions to the management of obesity involve food restriction and lower calorific intake, actively supported by encouragements of active exercise and self-controlled food consumption. Drugs are administered not as cure for mental disorder or mental illness but as part of weight management to aid weight loss. Drug administrations and weight management, programmes can only be introduced with the informed participation of the individual. At every stage, the individual should have the freedom to either accept or reject any medical discourse unaligned with their choices and values. The implication is that regardless of ever-pressing health issues, individual autonomy and freedom should remain uncontained or unrestricted. If anorexia is because of less food consumption and obesity because of excessive eating, it becomes difficult to understand why obesity is not classified as a mental disorder.

2.5 Non-Western Cultural Context

Gray insists that anorexia nervosa is one of the culture related syndromes gradually emerging in non-western societies. It is also being registered that the challenge between “culture and the treatment of anorexia is that of gender”.³⁸⁸ Anorexia nervosa in western cultures reinterprets body disturbances through biological transformation and is customarily considered extinct outside Europe and North America.³⁸⁹ The emerging knowledge of cultural significance of self-starvation is not entirely new, as

³⁸⁷ *Ibid.*

³⁸⁸ Sing Lee, ‘Reconsidering the Status of Anorexia Nervosa as a Western Culture-bound Syndrome’ (1996) 42(1) Social Science and Medicine Journal pp. 21-24.

³⁸⁹ Simpson, *op. cit.*

shared belief of indigenous values has become sustained outside western biomedicine.³⁹⁰ Distinctive engagement of the added perspective of the individual is often constructed outside diagnostic prejudice that idealises human suffering as a significant aspect of self-starvation. Although sufficient evidence reveals the presence of anorexia in non-western countries, Keel and Klump, however, suggest that anorexia may not be a culture bound syndrome as real weight loss concerns are not significantly evidenced in non-western regions.³⁹¹ Furthermore, self-starvation and issues of weight loss might be confined only to “social historical contexts that idealise thinness and denigrate fatness”.³⁹² According to Lee, fatness has come to represent “ugliness, shame and sin” in western culture whereas thinness represents self-control, desirability and beauty.³⁹³

Anorexia nervosa appeared in North America and Western Europe in the 1970s for the first time. Its prevalence has increased through the closing part of the twentieth century, when it emerged it was mostly among adolescent girls and young women who belong to the middle and upper classes. At this time, dieting became the order of the day and thinness became the ideal female shape or size. It was also noted that weight control became difficult as there was availability of high fat food at an increased level. About 1 and 2 percent of women in these western industrialized cultures could be regarded as suffering from anorexia nervosa. This is not the case in non-western cultures where the western habits and cultures are still at their low level. Besides affecting the type of behaviours and syndromes manifested by people, culture

³⁹⁰ Lee, *op. cit.*

³⁹¹ Pamela K. Keel and Kelly L. Klump, ‘Are Eating Disorders Culture-bound Syndromes? Implications for Conceptualizing their Etiology’ (2003) 129(5) *Psychological Bulletin* pp. 747-769.

³⁹² *Ibid.*

³⁹³ Lee, *op. cit.* p.22.

also affects clinicians' decision to label a behaviour as a disorder. An example is the case of homosexuality.

In the unlikely case subjective meaning to food refusal is engaged outside the biomedical discourse and assumption, the end process is to enable clinicians treat or manage the anorexic body more efficiently.³⁹⁴ Analysing other non-western pattern outside the premise of redressing self-starvation is not a formality readily implemented within the biomedical discourse.³⁹⁵ The role of the DSM is to facilitate the detection of the underlying substructures of mental illness and then proffer treatment thus unintentionally excluding native metaphors thereby disenfranchising culture-bound narratives.³⁹⁶ The standard set by the DSM criteria will then require a universal feeling of fatness across all cultures to achieve the fat phobia requirement regardless of physical emaciation. Multiple rationales for food refusal already support the monocratic classification in western discourse, which highlights the characteristics of each factor, as they exist uniformly fulfilling biomedical DSM criteria.³⁹⁷

While western societies have science-backed theories on the intense fear of weight gain occasioning body image disturbance, this is not the obvious case in some non-western countries. Simpson asserts that multiple evidence reveal that 'anorexia can exist without the fear of fatness'.³⁹⁸ The reason for food refusal varies and is often simplified by its association with other somatic symptoms, which include abdominal bloating and fullness. Regardless of the physical deterioration of the individual, medical diagnosis of anorexia nervosa is very unlikely. The symptoms the individual

³⁹⁴ Sing Lee, 'Self-starvation in Context: Towards a Culturally Sensitive Understanding of Anorexia Nervosa' (1995) *Social Science & Medicine Journal* pp.25-36.

³⁹⁵ *Ibid.*

³⁹⁶ Lee, *op. cit.* p.27.

³⁹⁷ *Ibid.*

³⁹⁸ K. J. Simpson, 'Anorexia Nervosa and Culture' (2002) 9(1) *Journal of Psychiatric and Mental Health Nursing*. pp.65-71.

exhibits are classified and treated as the disease rather than an illness. In constructing food analogies in non-western culture, the issue of food restriction is commonly discussed in relation to weight management rather than in understanding medical meanings underlying food consumption. Weight deviants are accepted within these non-cultures and therefore the western categorised abnormal feeding patterns are considered non-definitional practices. Invariably, stigmatization and criticism of the body whether fat or thin diminishes as there are no polarised dichotomy. For example, fasting may be a culturally sanctioned expression of religious prayer in the Middle Eastern countries but a symptom of an underlying disorder in some other cultures. Fasting however occurs for only short periods and usually symbolises self-denial to receive blessings from God and it is unrealistic to assume religious fasters within disordered eating. Therefore, individuals who do not fit into the model medical spectrum, even though they may be showing cultural diversity in the expression of a psychiatric disorder, will not receive appropriate attention. It therefore presents questions for individuals who do not fit into the DSM approach of regarding “fat phobia” as the core of anorexia nervosa. Understandably, “fat phobia” has become the constructed and constricted template that should conveniently discard anyone who does not fit in. This has rendered the detection of reliable cross-cultural differences almost impossible. In addition to the cultural differences in eating patterns, Coon and Mitterer point out that cultural values affect the incentive value of foods consumption. Categorising some foods as tasteful and others as distasteful influences the way an individual views and relates with food.³⁹⁹ For instance, goat head and cow tongue are considered delicacies in Nigeria. China hosts the popular annual Yulin dog festival

³⁹⁹ *Ibid.* p.328.

where thousands of dogs are slaughtered and presented for consumption.⁴⁰⁰ This is similar to Cross River state Nigeria where dog meat is consumed daily and represent a viable million-naira business.⁴⁰¹ There is also the culture bound myth of dog meat as offering protection against evil spirits and harmful charms, offering strength, enhancing sex life and even a cure for malaria.⁴⁰² Cultural bias is evident as including dog meat as part of a traditional delicacy does not form part of other cultures and often viewed as barbaric and cruel.

On culture, ethnicity and dieting, Coon and Mitterer opine that women in western countries see themselves as “objects” that others seem to be evaluating.⁴⁰³ This perspective conditions the body as an object of desire to the male gender thus restrictive food consumption is a mantle of ownership and regulation. Western cultural ideals of fat phobia are such that women succumb to dieting to ensure they shape their body to slimness. The role of culture makes them anxious of adding weight. Nevertheless, this is not the case with women from some other cultural settings. Such other women tend to be less concerned about thinness and so have no business glorifying it. This is what happens with Asian American College students who are less likely to diet when compared with other college women. A fuller and shapelier figure is what African American and Pacific Islander women generally prefer. These communities view their larger body size as a reflection of beauty, health and high social status. Thus, people’s opinions determine what should be considered as an attractive body style.

⁴⁰⁰ Independent, ‘Yulin Dog Meat Festival: What is it, How Did it Start and Will Activists ever Manage to Get it Banned?’ (2018) available at <https://www.independent.co.uk/travel/news-and-advice/yulin-dog-meat-festival-explainer-what-is-it-when-start-banned-controversy-a8410426.html> [accessed 6th November 2018].

⁴⁰¹ Sun Newspaper, ‘Dog for Dinner’ (2016) available at <https://www.sunnewsonline.com/dog-for-dinner/> [accessed 6th November 2018].

⁴⁰² BBC News, ‘Dogs for Dinner Prove Popular in Nigeria’ (2007) available at <http://news.bbc.co.uk/1/hi/world/africa/6419041.stm> [accessed 18th August 2019].

⁴⁰³ Coon and Mitterer, *op., cit.* p.384

Critical analysis of reasons why people elect self-starvation has undergone multi-varied dissection. At the core of this analysis is biomedical evidence of anorexia affecting only the female influenced by media culture, which dominantly extends to the fashion and advertising industries. Cultural ideal of female attractiveness has apparently been determined by magazine advertisements for some decades and women anxiety over weight gain leads to the emergence of anorexia nervosa. Alloy, *et al* recall major contributor is the fact that girls in America tend to base their notion of beauty on the fashion models who are mostly extremely thin.⁴⁰⁴ Fat phobia appears to be spreading from pre-teenage groups, as many as 9-year-old girls fear becoming fat, and so appear to be dieting to control their weight.⁴⁰⁵ Those who meet some of the criteria for anorexia, otherwise called “partial syndromes” (usually not enough to receive the diagnosis) are included in the definition of fat phobic girls at risk of developing the anorexic body. The implication is that the entire biomedical discourse builds on the fat phobia premise and has not extended to include cultural patterns not peculiar in western culture. Lee therefore argues that western construction of anorexia based only on fat phobia has “neglected the full metaphorical significance of self-starvation and when applied across cultural context, may constitute a category fallacy”.⁴⁰⁶ Biomedical conceptualisation is on the premise that intense fear of food is the underlying factor precipitating anorexia. However, the newly emerging non-western consideration in both Asian and African countries has questioned analysis of anorexia as a western syndrome. Historical trace reveals that the fear of weight gain did not constitute the reason for self-starvation and clinical approach only showed

⁴⁰⁴ Alloy, *et al.*, *op. cit.* p.448

⁴⁰⁵ *Ibid.*

⁴⁰⁶ Lee, *op. cit.* p.29.

more engagement with lived experience rather than fulfilling scientific diagnostic criteria.⁴⁰⁷

Gray is concerned with cultural variations in disorders and believes that cultural constructs is involved in determining disorders.⁴⁰⁸ There is great variation among cultures on what determines disorder. These include the kinds of distress the person is experiencing, the way these people express the distress, and even the way observers respond to the person that is distressed. Apart from changing from culture to culture, these constructs also vary from time to time in any particular culture. Whether any particular syndromes are considered disorders or behavioural variations from the normal is determined by cultural beliefs and values. According to Gray, the most striking evidence of cultural variations that exist is possibly found in by observing the individual within the environment where these values, beliefs and experiences are formed⁴⁰⁹. Some cultures tend to admit some syndromes as exaggerated forms of behaviour acceptable in modern times by some culture.⁴¹⁰ An example of the syndrome is one of the most common disorders diagnosed in Japan called “taijin kyofusho”, which is not known in other parts of the world. The disorder is found more in males than females. It involves an incapacitating fear of offending or harming another person by means of the person’s awkward social behaviour or an imagined physical defect. The person may believe he or she is offending others in various ways – including blushing, eye contact, or imagined physical defect or by emitting offensive or foul odour.⁴¹¹ The conscious fear associated with “taijin kyofusho” focuses on the possibility of harming others instead of the possible harm one could

⁴⁰⁷ *Ibid.*

⁴⁰⁸ Gray Peter, *Psychology* (New York, Worth Publishers 2007). pp.348-350.

⁴⁰⁹ *Ibid.*

⁴¹⁰ *Ibid.*

⁴¹¹ *Ibid.* pp.351-352.

get from others, like being ridiculed or rejected. Could this be a pathological exaggeration of the modesty and sensitive regard accorded people especially those at lower levels, as some Japanese psychiatrists seem to believe.⁴¹² Taking the role of culture into consideration highlights the individual meaning of food refusal and establishes a synergy to engage the ever-altering biomedical discourse. The non-western culture dimension authenticates the presence of non-fat phobic self-starvation. Notwithstanding the physical changes in body proportions, individuals within these cultures can communicate subjective meanings outside the fear of weight gain. This new pathway of validating life experience and engaging subjective meanings presents a binary medium to reevaluating food refusal from a non-western perspective.⁴¹³ Unification across other cultures is impossible; therefore, a cultural sensitive analysis of anorexia would include meaningful individual values and life experiences outside the intense fear of weight gain.⁴¹⁴ Normative discontent in non-western cultures is placed on fat phobia rather than on direct experiences and how such experiences affect individual identities. Western ideals therefore do not represent the uniform presentation of anorexia nervosa neither does the diagnostic criteria furnished by DSM-5⁴¹⁵

⁴¹² *Ibid.*

⁴¹³ *Ibid.*

⁴¹⁴ Lee, *op. cit.*

⁴¹⁵ Simpson, *op. cit.* p.66.

CHAPTER THREE

Meaning Centred Approach

3

Chapter two concluded by examining anorexia within a non-western context, which establishes the background for further discussions of the meaning centred approach in the next chapters. Identifying the non-cultural contexts that reflects the values of experiences and choices highlights an alternative narrative and meaning to self-starvation thereby questioning the medical model of anorexia as exclusively a psychiatric illness. It therefore presents an erroneous conclusion for clinicians to rely solely on a dimension that does not distinguish attributes from actions. The premise is that if clinicians can acknowledge an alternative dimension, a meaning centred positive perspective can emerge. It therefore follows that although anorexia is one of behavioural disorders associated with abnormality, there is however more reliance on the negative feeling and functioning of self-starvation. Approaching self-starvation from a positive perspective rather than solely pathology removes the complexity of abnormally. There is an overt dependence on a single concept or conceptual consensus on the clinical manifestation of anorexia as a disease presenting an alternative approach presents the freedom to implement other social values within the meaningful normalities which enhance individual autonomy. This present chapter starts with a brief discussion of gender subjectivity of self-starvation. The aim is to establish anorexia nervosa as affecting mostly the female gender and the ethical dilemmas of the female anorexic body seeking autonomy and self-determination

outside the traditional psychiatric and biological conception of eating disorder. The outcome opens up a broader discussion of body image perception; self-expressions and liberation, which is core in the discussion of the meaning centred anorexic body in chapter four. The second part of this chapter examines the nature and ranges of the meaning centred approach, which recognises the interplay of the multifaceted nature of anorexia.

3.1 Critical Perspective

Eating disorders are well noted as affecting mostly the female gender.⁴¹⁶ Shaffer and Kipp report that a number of psychological factors affect puberty and those dramatic physical changes encountered by young girls are bothersome.⁴¹⁷ Young girls therefore become very concerned with perception and analysis of others to their body changes.⁴¹⁸ Generally, it is the desire of the adolescent girls to be perceived as attractive and therefore anticipate bodily changes to be congruent with the feminine ideal of slimness.⁴¹⁹ Negative body perceptions are observed from early to late adolescence. For instance, well-proportioned adolescent girls tend to compensate for any physical fault by slouching.⁴²⁰ It is therefore not unusual for adolescent girls that have their bodies developing at a pace different from average are very prone to internalising negative body image.⁴²¹ Shaffer and Kipps further report that body dissatisfaction has become so predominant for women especially adolescent girls and adult women

⁴¹⁶ Heather C. Pizzanello, 'Evolving from an Illusionary and Self Destructive Quest for Power to a State of Empowerment: The Curative Potential Yoga May Hold as a Vehicle to Reclaiming Bodily Empowerment for Women with Anorexia' (2016) 43(4) *Journal of Sociology and Social Welfare* p.37.

⁴¹⁷ David R. Shaffer and Katharine Kipp, *Developmental Psychology: Childhood and Adolescence* (Wadsworth, Cengage Learning 2013) p.222.

⁴¹⁸ *Ibid*, p.223-224

⁴¹⁹ *Ibid*.

⁴²⁰ *Ibid*, p.228

⁴²¹ *Ibid*, p.228-229

groups to the extent that it is considered as a normative component of how they live in Western societies.⁴²² Generally, girls choose a weight control measure based on the type of body image dissatisfaction the adolescent girl is experiencing. The desire to become thin and reduce weight is what prompts girls to diet. The period of growth in adolescence is very critical to the extent the adult normal stature and reproductive capacity is achieved. Unhealthy weight control obviously has physical consequences on nutrition and growth. There is much risk for adolescent females who continually diet. Such girls are known to consume lower quantities of grains, vegetables and fruits when compared with the girls that do not diet. Some of these adolescents progress to a point of disorder, from simple dieting. Anorexia nervosa is seen as feminine disorder predominant when adolescent girls and young women become obsessively concerned about their possible weight gain. Understandably, the explanation for the prevalence of anorexia in female can be as a result of the dominant cultural stereotype, which exploits the ideologies of feminine beauty.⁴²³ Various writers have identified anorexia as not only gender specific but also prevalent within a class system. Taylor asserts that anorexia is most prevalent among the adolescent females from the upper class.⁴²⁴ Gazzaniga, et al also note that anorexia nervosa is predominant amongst adolescent girls of these socio-economic classes.⁴²⁵ Santrock also notes that most anorexics are white adolescents or young adult females from well educated, middle and upper income families that are competitive and over-achieving.⁴²⁶ Gross views anorexia nervosa as the controlled lack of appetite that usually begins in adolescents aged 16 to

⁴²² *Ibid.*

⁴²³ Science News “Understanding Anorexia” (2015) available at <https://www.sciencedaily.com/releases/2015/02/150219101345.htm> [accessed 6th June 2019]

⁴²⁴ Taylor, *op. cit.*

⁴²⁵ Gazzaniga, et al, pp. 302.

⁴²⁶ Santrock, *op., cit* p. 533.

17 years, 90 to 95 percent of whom are females and advances to adulthood.⁴²⁷ Alloy et al also add that anorexia is mostly found among adolescent girls and young women.⁴²⁸ Majority of people with anorexia nervosa (85 percent to 95 percent) are females having an on-set that ranges from 12 to 18 years of age. It is equally possible to find females diagnosed before puberty, and even females who are up to 30 years of age being diagnosed.⁴²⁹ Gleitman, et al note that the disorder is more common in societies that have plenty of food but the most acceptable feature is thinness and identified the gender that is more involved and the period of onset.⁴³⁰ Anorexia nervosa therefore starts in mid-adolescence and is prevalent among females mostly in industrialized societies where the disorder afflicts up to one percent of young people who embark on the relentless pursuit of food refusal or self-starvation.⁴³¹

Reoccurring feminine interaction with anorexia begins as young as the body goes through the puberty phase. The process of arriving at the anorexic body is gradual as the individual strategically restricts food intake and in some cases embraces vegetarianism before progressing to become a person with an abnormally low body weight.⁴³² Vasta, et al also note that anorexia nervosa is an eating disorder associated mostly with young women.⁴³³ These young females voluntarily choose to embark on very severe dietary restrictions and by so doing embrace self-starvation until their desired body weight is accomplished.⁴³⁴ The female body has therefore remained the focal point of feminist discussions and dissections especially on critical issues of womanhood and individualised projections of the body. In most cases, the transition

⁴²⁷ Gross, *op. cit* p. 772

⁴²⁸ Alloy et al., *op. cit.* p. 447

⁴²⁹ *Ibid.*

⁴³⁰ Gleitman *et al*, *op.cit.* p.728.

⁴³¹ *Ibid.*

⁴³² *Ibid.*

⁴³³ Vasta, et al, *op.cit.* p.187

⁴³⁴ *Ibid.*

from pubescent to adulthood creates self-doubts and conflicts bothering on identity and normalisation. Weight loss and gain at every stage of the development of the female body remain within the interest and dialogue of the male gender. In retrospect, the female body, which is subject of male dominance and control, becomes intertwined with conversations of freedom and independence without control and coercion. Resistance to the innate female gender subjectivity is embraced as part of feminine liberation from patriarchy and misogyny. In today's digital media world, prominence has been drawn to self-narratives of women seeking to regulate the meanings underlying the anorexic body whilst interacting with established traditional medical and media dialogues.⁴³⁵ Feminist narratives emerge in broader terms engaging gendered power-liberation from gendered oppression, self-expression and autonomy.⁴³⁶ Feminists analyses of the anorexic body, therefore, extend beyond self-starvation to subjective identity construction through self-representation.⁴³⁷ Mainstream accounts of anorexia only reference the physical emaciation of the anorexic body as central for analysis, disregarding the body proper as the core of expression and power.⁴³⁸ Western feminist approaches therefore encourages women to harness their authentic self, which sometimes involves body transformation to correspond with their inner truth or meaning.⁴³⁹ Invariably, for an individual's authentic self to emerge, self-identity is strengthened by autonomous actions that

⁴³⁵ Su Holmes, 'My Anorexia Story: Girls Constructing Narratives of Identity on YouTube' (2017) 31(1) Cultural Studies Journal pp. 1-2.

⁴³⁶ *Ibid.*

⁴³⁷ *Ibid.* p. 3-5

⁴³⁸ *Ibid.*

⁴³⁹ *Ibid.* pp.12-13.

fulfil a greater purpose.⁴⁴⁰ Feminism in this instance “emerges here as appropriate and sanctioned in terms of women having rights”.⁴⁴¹

Critical feminist theories challenging treatment mechanisms, which do not incorporate the experiences, values and voices of the anorexic body emerged in the 1980s.⁴⁴² The extent of scrutiny surrounding the female body rituals seems to increase, specifically the way their body transitions without conforming to medical or psychiatric concepts.⁴⁴³ Central to feminist approach is a distinctive “emphasis on the medical and psychiatric discourses as historically contingent constructions” which enables the detachment of an individual from their autonomy.⁴⁴⁴ The challenge is that the anorexic body is only explored metaphorically rather than seeking an in-depth meaning to the anorexic experience.⁴⁴⁵ The problem lies in the way clinicians constantly attempt to draw a clear demarcation between the body proper (object) and the constructed body (subject) especially as the lines are blurred by the physical manifestation of the effects of the resistance categorised as diagnostic symptoms. The object exhibits the symptoms, however the subject embodies the reality, remaining unbiased and self-determined. According to Holmes, emerging feminist objectives are centred on contesting the way a woman’s self-expression is subdued especially regarding the “..interpretation of their starving, treatment and construction”.⁴⁴⁶ The female body is therefore well acknowledged as a feminist issue, especially as the

⁴⁴⁰ Cressida J. Heyes, *Self-Transformations: Foucault, Ethics, and Normalized Bodies* (New York, Oxford University Press 2007) p.4.

⁴⁴¹ Su Holmes, Sarah, Drake, Kelsey Odgers & Jon Wilson, *Feminist Approaches to Anorexia Nervosa: a Qualitative Study of a Treatment Group* (2017) 5(36) *Journal of Eating Disorders*. pp.1-15.

⁴⁴² Su Holmes, ‘Between Feminism and Anorexia: An Autoethnography’ (2016) 19 (2) *International Journal of Cultural Studies*, pp.193 -195.

⁴⁴³ *Ibid.*

⁴⁴⁴ *Ibid.* p.196-197.

⁴⁴⁵ *Ibid.*

⁴⁴⁶ *Ibid.*

body transitions from a physical organism into a concept that truly validates their identity.⁴⁴⁷ The existing medical discourses are “historically specific”, dissuading any conceptualisation of theories that attributes individualised meaning to self-starvation.⁴⁴⁸ However, it is noteworthy that feminist perspectives championing liberation autonomy of the anorexic body has suffered accusations of promoting false consciousness.⁴⁴⁹ The argument is based on existing psychiatric and medical discourse, which insists that the systematic practices of the anorexic reflecting social and political understanding, is made involuntarily.⁴⁵⁰

Bordo⁴⁵¹ and Orbach⁴⁵² however present a united analysis of the starving body as a form of corporal resistance and escape from patriarchal manipulation. Bal and Dikencik note that, “in the case of anorexia, women were always in the focus, because statistically they were ten times more likely to suffer from anorexia”.⁴⁵³ Shared interests of body feminists over the years have become broadened to explore body image and self-starvation outside confined generating critical dialogues on the conception of the feminine body as a cultural and political model.⁴⁵⁴ In the western world, Bruch notes that the primary cause of anorexia in women is the wide spread of pressure and scrutiny imposed on them to stay thin.⁴⁵⁵ There is also the contributed factor of aspiring to fit into the societal standard of beauty and perfection, which

⁴⁴⁷ Morag MacSween, *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa* (Oxon Routledge 1993) p. 38.

⁴⁴⁸ Holmes, *op. cit.* pp.196-198.

⁴⁴⁹ *Ibid.*

⁴⁵⁰ *Ibid.*

⁴⁵¹ Susan Bordo, *Unbearable Weight: Feminism, Western Culture and the Body* (London, University of California Press 2003) p. 212.

⁴⁵² Susie Orbach, *Hunger Strike: Starving Amidst Plenty* (London, Penguin 1993) pp. 1–12.

⁴⁵³ Zeynep Ekin Bal and Muge Caroline Dikencik, ‘Anorexia Nervosa as a Modern Disease: A Comparative Study of Different Disciplines’ (2013) 82 Social and Behavioral Sciences Journal p.495.

⁴⁵⁴ Susan Bordo, ‘Reading the Slender Body’ in Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (eds.), *Body/Politics: Women and the Discourses of Science* (New York, Routledge 1990) pp. 83-84.

⁴⁵⁵ Bruch, *op. cit.*

historically is identifiable with the media-portrayed thin body. The increasing number of individuals who adapt to this slender, thin and willowy aesthetics stimulates a broadened understanding and interpretation through in-depth analysis,⁴⁵⁶ which redefines the body anatomy through control as a symbol of self-accomplishment. Foucauldian literature has influenced contemporary thinkers to objectify the influence of unwanted action over the body. The interpretation of terms of subjective experience created a movement against own oppression by ensuring an alignment to the development of themes that reflect a greater autonomy.⁴⁵⁷ A study conducted at the Cornell Medical College, New York, on eating disturbance in Eastern and Western societies detected a cultural pattern of food starvation as a tool for “negotiating the transition, disconnection, and oppression that they uniformly endure.”⁴⁵⁸ Katzman and Lee share the perspective that sole focus on body image and starvation will only bypass the superior acknowledgement surrounding the conceptualised structure of the anorexic body.⁴⁵⁹ The quest for body perfection becomes symbolic with actions of staying in control. According to Izzy, “eating has come to represent much more than simply food. Their emotions, fears and sense of identity are wrapped up in food/weight”.⁴⁶⁰ It is not a mere strategic uncontrolled expression reoccurring intermittently. Appropriate representations will require believing in the attitude of worth and integrity a person accepts and in many ways the body is a temple, a place of self-worship and service. Voluntary starvation enables

⁴⁵⁶ Bordo, *op. cit.*, p.206.

⁴⁵⁷ Monique Deveaux, ‘Feminism and Empowerment: A Critical Reading of Foucault’ (1994) 20(2) Feminist Studies pp. 223–247 available at http://www2.kobe-u.ac.jp/~alexroni/IPD%202016%20readings/IPD%202016_8/Feminism%20and%20Empowerment_%20A%20Critical%20Reading%20of%20Foucault.pdf [accessed 5th January 2019].

⁴⁵⁸ Melanie A. Katzman and Sing Lee, ‘Beyond Body Image: The Integration of Feminist and Transcultural Theories in the Understanding of Self Starvation’ (1997) (22) International Journal of Eating Disorder p.385.

⁴⁵⁹ *Ibid.* p.386.

⁴⁶⁰ Life Without Anorexia available at <http://www.lifewithoutanorexia.com/p/myself.html> [accessed 5th October 2019].

conscious gratification and satisfaction in the feeling of hunger, an achievement equated to making a critical statement reinforcing the underlying connotation to food refusal. The resistance of the normalised body weight, therefore, becomes a mantle of self-conservancy and protection. In that sense, there is an overwhelming empowerment in having that type of control and expressing autonomy with no inhibitions.⁴⁶¹

3.2 Understanding the Meaning Centred Approach

Numerous approaches have been developed over the years to aid the analysis of scientifically elusive disorders such as anorexia nervosa. Clinician's focus on the disease aspect of the anorexic behaviour therefore treatment models are initiated to only tackle the extreme desire to be thin as the sole reason for self starvation. Patient centred approaches are not designed to include the values, morals and decisions of the individual. Anorexics are therefore intensely and continually in pursuit of recognition and self-actualisation through thinness. Low calorific intake explains not just the anorexics attitude to food but a sign of a desire to control and assert authority over how their body develops. In other words, to produce a rounded study on behavioural and eating patterns that signify anorexia, meaning within social-cultural contexts must emerge. Culture bound research outcomes have highlighted the need for more focus on "addressing meaning" in clinical practice and treatment of mental disorders in general.⁴⁶² Connecting the subjective meaning behind self-starvation has not being of medical relevance especially in the treatment and management of anorexia nervosa. The multifaceted nature of anorexia is such that to accurately engage with the

⁴⁶¹ Hilde Bruch, *The Golden Cage: The Enigma of Anorexia Nervosa* (Cambridge, Harvard University Press 2001) p. 3.

⁴⁶² Efren Y. Martinez and Ivonne A. Florez, 'Meaning-Centered Psychotherapy: A Socratic Clinical Practice' (2015) 45(1) *Journal of Contemporary Psychotherapy*, p.45.

interplay of the multiple sub-structured variables, the culture and life experience of the individual must be aligned. Accounts of the individual choices are never given prominence, rather in-depth psycho-legal analysis of other external factors triumphs an individualistic view. The overarching question remains how best can meaning be deduced and in what context? The challenge with attempting a meaning centred analysis of anorexia nervosa rests on the uphill tasks of finding a balance between the over-emphasised medical alarms of impending death and severe health consequence should individual refuse medical treatment. The universal application of mental health law in western societies does not declassify or provide different levels of approach depending on individual profile. Once the overall diagnostic criteria are met, the individual would invariably fit the profile for detention and treatment without consent. This western bound extant system cannot solely thrive under the new emerging social-cultural realities. Especially considering that the biomedical systems have relaxed the strict diagnostic criteria to recognise the current existence of mild types of anorexia.⁴⁶³

Frankl also identifies a new variety of mental disorder, disassociated from established biological symptoms.⁴⁶⁴ Individuals within this spectrum exhibit unique characteristic that do not fully correspond with the established medical diagnostic criteria; therefore the validity of enforcing same treatment or management procedures should be questioned.⁴⁶⁵ The issue here is that clinicians are specifically equipped to tackle the general clinical symptoms but unprepared when confronted with unfamiliar and uncharacterised behaviour.⁴⁶⁶ Identifying mild types of anorexia may not be sufficient

⁴⁶³ Sing, *op. cit.* p.29.

⁴⁶⁴ Viktor E. Frankl, *The Feeling of Meaninglessness: A Challenge to Psychotherapy and Philosophy* (Wisconsin, Marquette University Press 2010) pp. 45-46.

⁴⁶⁵ *Ibid.*

⁴⁶⁶ *Ibid.* p.84.

as theoretical and practical limitations still exist, reinforced by mental health laws and legislation. Understandably, an argument for the recognition of the existence of mild forms of anorexia will require reevaluating clinical observation and diagnostic criteria. It is, however, difficult for treatment practitioners to engage with the ideology that mentally stable and conscious individuals would voluntarily choose self-starvation and restricted food consumption regardless of the absence or presence of mental illness. Moreover, treatment professionals are reluctant to utilise non-biomedical approaches and in some countries have progressed a step further to suggest the criminalisation of any behaviour that indicates mental illness.⁴⁶⁷ Cultural trends have revealed that self-starvation develops and is preserved through adolescence to adulthood. Understandably, within those core stages, meaningful moments are registered and are found to form part of the individual's identity.⁴⁶⁸ According to Shaffer and Kipp's report, many adolescents experience eating disorders between 12 and 20 years, for the first time. But the peak is said to be between 14 and 18 years. Reports equally indicate the observation of the symptoms among children aged 3 to 6 years.⁴⁶⁹

Current research does not reveal the application of the meaning centred approach in the analysis of eating disorders. Schles discusses the application of an individualized meaning-centred approach to braille learning applied to individuals with multiple disabilities.⁴⁷⁰ Meaning Centred Approach was utilised to develop a method of

⁴⁶⁷ Marc F. Abramson, 'The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law' (1975) 23(4) Hospital and Community Psychiatry Journal p.101.

⁴⁶⁸ Barry Rosenfeld, Rebecca Saracino, Kristen Tobias, Melissa Masterson, Hayley Pessin, Allison Applebaum, Robert Brescia, and William Breitbart, 'Adapting Meaning-Centered Psychotherapy for the Palliative Care Setting: Results of a Pilot Study' (2017) 31 (2) Palliative Medicine. Pp.144-45.

⁴⁶⁹ Shaffer, *et al*, *op. cit.* 46-48.

⁴⁷⁰ Rachel A. Schles, 'Individualized Meaning-Centered Approach to Braille Literacy Education (I-M-ABLE) Case Study: Ajay's Story' (2015) 109 (1) Journal of Visual Impairment & Blindness p.60.

communication unique to the individual, which enabled the inclusion of his or her own stories and experiences. Multiple outcomes of the study revealed that individual decisions to participate and learn to read by touching instead of sight (braille) were stimulated by consent and ability to denote meaning.⁴⁷¹ The key instrument to the success of the meaning-centred approach (MCA) above other approaches, therefore, was the individualised appeal to the personal relevance and intricate values of the student.⁴⁷² It is therefore particularly striking that individual assessment which places the individual as the lead in his or her own life decisions has shown more success potential than when they are excluded from these decisions. Wormsley notes that changing from the pre-established traditional approach to the nascent MCA was instrumental to underscoring progress.⁴⁷³ In palliative care, for instance, there was key focus on reinforcing and strengthening the meaning behind their experience. According to Rosenfeld et al, MCA to psychotherapy for palliative care involved sessions, which “addressed the person’s own understanding of meaning and experience of meaning in his or her life.”⁴⁷⁴ Critical accounts of meaningful and historically significant capabilities that formed part of the individual’s identity was crucial in improving quality of life.⁴⁷⁵ Wong places the survival of humanistic psychology to an adaption of a MCA. Revisiting suppressed themes of “personal growth, self-actualization, authentic happiness, optimal function and human flourishing” is essential to reserve the diminished aspects of humanistic

⁴⁷¹ Jill McMillian, ‘A Student Success Story through the Use of an Individualized Meaning Centered Approach to Braille Literacy (I-M-ABLE)’ (2015) 109 (1) *Journal of Visual Impairment & Blindness* p.65.

⁴⁷² Diane P. Wormsley, ‘A Theoretical Rationale for Using the Individualized Meaning-Centered Approach to Braille Literacy Education with Students Who Have Mild to Moderate Cognitive Disabilities’ (2011) 105 (3) *Journal of Visual Impairment & Blindness* p.145.

⁴⁷³ *Ibid.*

⁴⁷⁴ Rosenfeld, et al, *op. cit.* pp.144-45.

⁴⁷⁵ *Ibid.*

psychology.⁴⁷⁶ Wong's MCA account highlights inherent themes for individuals to lead a dignified and valued life without fear of inhuman or degrading treatment, which can suppress their experience.⁴⁷⁷

In a way, there is a conscious reminder that for an individual to achieve optimal levels of success, a level of autonomy and liberty is pertinent. However, clinicians argue that authentic happiness will never be fully achieved neither can an individual reach their full potential when the body is suffering from self-starvation. Dubois asserts that anorexia nervosa signify a body and mind convergence which indicates a psychosomatic disorder.⁴⁷⁸ However, without conclusive data, suggestions of anorexia conformity to compulsion neurosis have not been scientifically established.⁴⁷⁹ Thus, the presence of mental illness means that most actions of anorexics are made involuntarily and such decisions cannot be classified fulfilling and rational. This might be true if anorexia has been proven to exist on the compulsion neurosis spectrum where biological sufferings of the anorexic is fully unconsciously and compulsorily made and determined. Clinicians constantly have attempted to link anorexia to obsessions and compulsion neurosis by comparative analysis of the contributing factors between symptoms of anorexia and obsessive-compulsive disorder (OCD).⁴⁸⁰ No identical symmetry was found because the latter exists in a frequency bothering on neurosis.⁴⁸¹ Relatively, in the absence of neurosis, the

⁴⁷⁶ Paul T. P. Wong, 'A Meaning-Centered Approach to Sustainable Growth and Radical Empiricism' (2011) 51(4) SAGE Journals pp.408 – 412.

⁴⁷⁷ *Ibid.*

⁴⁷⁸ Franklin K. Dubois, 'Compulsion Neurosis with Cachexia (Anorexia Nervosa)' (2006) 106 (2) American Journal of Psychiatry pp.107-115.

⁴⁷⁹ *Ibid.*

⁴⁸⁰ Walter H. Kaye, Theodore E. Weltzin, , George L.K.. Hsu, Cynthia Bulik, Claire McConaha, and Theresa Sobkiewicz, 'Patients with Anorexia Nervosa Have Elevated Scores on the Yale-Brown Obsessive-Compulsive Scale' (1991) 12(1) International Journal of Eating Disorders pp.57-62.

⁴⁸¹ Katherine A. Halmi, Suzanne R. Sunday, Kelly L. Klump, Michael Strober, James M. Leckman, Manfred Fichter, Allan Kaplan, Blake Woodside, Janet Treasure, Wade H. Berrettini, Mayadah Al

anorexic body embodies a certain level of awareness and is motivated by the quest for self-satisfaction and acquisition, which often translates to happiness, contentment and self-satisfaction. Bank asserts that although there maybe parts of the anorexics biological dysfunctions that are not consciously determined, however, it is pertinent to note that: “the anorectic consciously understands and gives meaning to her symptoms using culturally explicit and objective symbols, beliefs and language.”⁴⁸² Every disorder is unique and significantly resonates with the individual;⁴⁸³ meaning can be forged in an environment where individuals can excel as autonomous beings, retaining their experiences as part of their identity. A balanced analysis of contributing factors will include meaningful analysis of the meaning underlying an individual’s unconventional eating patterns.

Frankl, a former long-time Nazi prisoner, describes human beings as very complex, multi-dimensional souls, made up of very detailed intricate pieces (combination of a life time of experience) that can only be woven together to form meaning.⁴⁸⁴ One cannot therefore disassociate present being from the past. Having suffered the worst fate in concentration camps (violence, assault, hunger, and cold), the crucial aspect of Frankl’s writing suggests that in finding meaning, there must be pain and suffering. In essence, the gentle approach towards human suffering, indicating that pain and suffering whether physical, mental or emotional was an essential part of the human existential experience.

Shabboat, Cynthia M. Bulik, and Walter H. Kaye (eds). ‘Obsessions and Compulsions in Anorexia Nervosa Subtypes’ (2002) available at <http://eatingdisorders.ucsd.edu/research/pub/imaging/doc/2003/halmi2003obsessions.pdf> [accessed 10th May 2018].

⁴⁸² Caroline G. Banks, ‘Culture in Culture-Bound Syndromes: The Case of Anorexia Nervosa’ (1992) 8(34) Social Science Medical Journal p.868.

⁴⁸³ *Ibid.*

⁴⁸⁴ Viktor E. Frankl, *Man’s Search for Meaning* : The Classic Tribute to Hope from Holocaust (New York, Washington Square Press 1985) pp 11-16.

According to Frankl:

“The way in which a man accepts his fate and all the suffering it entails, the way in which he takes up his cross, gives him ample opportunity – even under the most difficult circumstances – to add deeper meaning to life. It may remain brave, dignified and unselfish. Or in the bitter fight for self-preservation he may forget his human dignity and become no more than an animal. Here lies the chance for a man either to make use of or to forgo the opportunities of attaining the moral values that a difficult situation may afford him. And this decides whether he is worthy of his sufferings or not.”⁴⁸⁵

Wong explains; “meaning is both personally construed and socially constructed, meaning is highly sensitive to individuals and cultural difference”.⁴⁸⁶ Invariably, in many ways, the perspective of the life experiences of an individual connects to their core mental form.⁴⁸⁷ Meaning Centred Approach is not regarded as formal theory⁴⁸⁸ and is unique or exclusive to a particular discipline although it has been applied in other areas of psychiatric models. Holmes considered the MCA as “comprehensive

⁴⁸⁵ *Ibid.*

⁴⁸⁶ Paul Wong, ‘Meaning-Centered Approach to Research and Therapy, Second Wave Positive Psychology, and the Future of Humanistic Psychology’ (2017) 45(3) *The Humanistic Psychologist* p.214 available at <http://www.drpaulwong.com/carl-rogers-award/> [accessed 12th May 2018].

⁴⁸⁷ Paul Wallang, ‘Wittgenstein’s Legacy and Narrative Networks: Incorporating a Meaning-Centered Approach to Patient Consultation’ (2010) 34 (4) *The Psychiatrist* p.160.

⁴⁸⁸ Geoffrey R. Thompson ‘Meaning-Centered Therapy for Addictions: A Case Study’ (2011) 10(3) *International Journal of Mental Health and Addiction* p.1

and multidimensional”.⁴⁸⁹ A MCA, therefore, enables the evaluation of multifaceted factors that occur in biomedical bound discourses by including the individuals lived experiences, choices and values in decision-making. This approach supports the fluidity of all aspects of a person’s experience which is manifested in the way the individual chooses to self-express, self-control or self-determine. The outcome should aid the realization that the underlying meaning behind the physical decline of an individual has been long overlooked.

Wallang argues that meaning has often been relegated to the background as focus is placed on fulfilling the systematic process of medical diagnosis. It might be essential to fulfil medical diagnostic criteria; however, it is also critical that the patient’s meaning is not forgone or relinquished.⁴⁹⁰ Wong notes that human beings are “by nature, meaning-seeking and meaning-making creatures who constantly make sense of their experiences in real life”.⁴⁹¹ The autonomous meaning behind a woman’s decision to redefine the body proper by creating a meaning-centred variation depicts an internal struggle against both medical and societal preferred identity. Invariably, the MCA to the anorexic body should be centred on personal experiences, which informs the autonomous choices and motivations of the individual to control the body through food resistance. The MCA appreciates the voice of the individual as central to dignifying their experiences, morals and choices. The individual is acknowledged and valued as a self-determining agent, adverse and resistant to the established stereotypical boundaries and impositions of psychology, law and psychiatry. The idea that there is significance to every thought, action and emotion exhibited by the

⁴⁸⁹ Jeremy Holmes, ‘Meaning-Centered Approaches: What about Psychodynamics’ (2010) 34(7) *The Psychiatrist* p.305.

⁴⁹⁰ Wallang, *op. cit.* pp. 157-158.

⁴⁹¹ Wong, *op. cit.* p.209.

anorexic body highlights the conscious elements in engaging the multiple dimensions that may arise within and outside the boundaries of autonomous expressions. In perspective, an individual's search for meaning or making sense of every minute element of their behaviours and relationships with other individuals in general demonstrates a significant degree of capacity. The interpretations of the individual actions in a way that provides logical meaning and understanding focuses on the role of the individual to provide in-depth perspective which reinforces the morals, belief and principle. Wong embraces the notion that the impact of recognising the meaning-centred nature of humans essentially captures the interface between their personhood and the desire to constantly self-regulate.⁴⁹²

Frankl insists that, "meaning must be found and not given. And it must be found by oneself, by one's own conscience".⁴⁹³ The implication is that clinicians can only attempt to illustrate the substructures of a disorder but cannot uncover the true meaning as every individual possesses their own values, which are applied to individual situations.⁴⁹⁴ Thompson notes that a huge void is created when the efforts of an individual to create a "personally meaningful life" is disregarded and relegated to the background.⁴⁹⁵ In treating alcoholism, for instance, incorporating the MCA was effective because alcohol abusers were primarily treated as individuals in control of their choices and not addicts lacking in consciousness and direction.⁴⁹⁶ The key component in managing the alcoholic's experience was based on acknowledging that there is a central meaning propelling substance abuse and which is determined first by

⁴⁹² *Ibid.*

⁴⁹³ Frankl, *op. cit.* pp. 45-46.

⁴⁹⁴ *Ibid.*

⁴⁹⁵ Geoffrey Thompson, 'A Meaning-Centered Therapy for Addictions' (2012) 10 (3) International Journal of Mental Health and Addiction p. 428.

⁴⁹⁶ *Ibid.*

acknowledging and understanding their subjective experience and secondly placing the human being in the centre stage. For Wong, there is an intrinsic meaning obtained by condensing transit experiences into a belief system which an individual can identify with and can lend an explanation to human behaviour and life itself.⁴⁹⁷ Researchers have long identified the significance of meaning as they engage and integrate with the process of living. The high view is that a person resides within their environment with challenges and problems that affect their everyday life whether mental, physical or otherwise. Those challenges invariably impacts their everyday experience as they begin to bond, withdraw or embrace the outcome by finding a system to internalise and understand those problems. Noteworthy outcome is also the capacity inherent in the individual to synthesise successfully and process multitudes of transit information acquired throughout their experiences to reflect their state of being. More specifically, engaging meaning also illustrates that the process of arriving at a conclusive outcome is valid and valuable and because of a well thought through consideration – not an immediate instantaneous, spontaneous abnormal mental trigger. Frankl identifies three core ways of finding meaning: firstly, through the conceptions that are impacted and impactful to the world; secondly, impressionable lived experiences and encounters; and finally, the act of determination and perseverance when confronted in situations beyond their control.”⁴⁹⁸ Frankl insists that meaning could be found in all circumstance and humans can therefore embrace the freedom of choice and they need to fulfill meaning and realise value”.⁴⁹⁹ If a person’s behavior can only be fully understood by taking into account his independent choices centred on meaning and values, it follows that it will be counterproductive to separate a person from the meaning informing their choice. In this context, evaluating

⁴⁹⁷ Wong, *op. cit.* pp. 207-216.

⁴⁹⁸ Frankl, p.179.

⁴⁹⁹ *Ibid.*

the state of a person's being must be done in terms of their meaning and values.⁵⁰⁰

There are experiences, which transcend the physical being and are at multiple levels intertwined with the human existence.⁵⁰¹

In a distinctive way, human beings are in constant search for a unique meaning, which defines them and portrays both their positives and negatives in a way that validates their own story and essence.⁵⁰² Meaning making have been regarded as an adaptive mechanism utilised by individuals in finding their identity and purpose to justify the outcome of their actions.⁵⁰³ Lichtenthal and Breitbart note the emergence of a redefined identity in parents mourning the death of a child as an outcome of making sense of the child's demise. Cultural and religious beliefs will play a part in sustaining and shaping the redefined identity after a traumatic experience as boundaries of belief systems are constantly tested by new experiences. It becomes appropriate that making sense would involve processing and integrating existing beliefs or trigger a change in beliefs by forming new ones. Whichever pathway the individual adopts, it seems necessary that the past beliefs, morals and values are reconciled with the present in order to forge a true identity and sense of self. Aligned in finding and acknowledging meaning is the route that takes into consideration all the negative and positive aspects of an individual, enhancing direction to self-determination and autonomous expressions. Consequently, the power to shape their experience is not delegated to a third party, as there is a clear development of an individualised undiluted identity. The individual's voice is prioritised in every decision-making. Unbiased interpretation of

⁵⁰⁰ Frankl, *op. cit.*, p.103.

⁵⁰¹ *Ibid.*, p.177.

⁵⁰² Frankl, *op. cit.*, p.178.

⁵⁰³ Wendy G. Lichtenthal and William Breitbart, 'The Central Role of Meaning in Adjustment to the Loss of a Child to Cancer: Implications for the Development of Meaning-Centered Grief Therapy' (2015) 9(1) Current Opinion in Supportive and Palliative Care pp.46-51.

their experience is fundamental to bringing a conscious and consensual patient-doctor relationship previously, which previously eluded the biomedical system.⁵⁰⁴ This narrative identifies and interprets what an individual's voice represents, presenting a non-layered perspective devoid of speculative accounts.⁵⁰⁵ According to Holmes, applying a MCA:

“...would better reflect the complex aetiology of mental illness and surely help create a humane working method which would promote a deeper understanding of our patients. It would also lead to the realization that our patients are equal participants and allow us move into the next phase of psychiatry, the overdue liberation of the patient's own voice, freeing them from any single interpretative or explanatory authority and allowing further recognition and hopefully alleviation of their suffering”.⁵⁰⁶

Treatment professionals have described the process of dealing with anorexics as “humbling”.⁵⁰⁷ Interactions between clinicians and anorexics are as strenuous and combative particularly when the patients do not consent to involuntary treatments. Personal narratives are important as they relate the account of the individual in a way that unifies complex systems and signs highlighting both past and new viewpoints on events, expressing their beliefs and offering insights into perceptions and impressions

⁵⁰⁴ Holmes, *op. cit.*, p.305

⁵⁰⁵ *Ibid.*

⁵⁰⁶ *Ibid.*, p.305.

⁵⁰⁷ Janice Russell, ‘Treating Anorexia Nervosa: Humbling for Doctors’ (1995) 311(7005) British Medical Journal p.584.

otherwise hidden to the external world.⁵⁰⁸ Clinicians continue to struggle to embrace a conceptual modification that includes individualised meanings of the anorexic body, which is totally different from established medical knowledge.⁵⁰⁹ Clinicians attribute the lack of acceptance and commitment to treatment to the values the individual places on self-starvation as a means of fulfilling their disorder. The clinical narratives presents the anorexics as irrational and unwilling to accept treatment options geared towards treating their mental disorder and relieving their physical symptoms.⁵¹⁰ Medical solutions are therefore solely focused on prevailing on the anorexic body to gain weight thereby creating a wide gap where the anorexic's complaints about treatment procedures are not constantly reviewed to ensure they are within ethical principles.⁵¹¹ Clinicians argue that their overall knowledge and scientific awareness of the detrimental effect of self-starvation to brain functions makes it impossible to consider principles of autonomy in the instance an emaciated individual refuses treatment.⁵¹² Invariably, interpreting their experiences and the meaning underlying their behaviour is valuable. Russell notes that because the anorexic body is in constant struggle to find balance and "secure sense of self", it means that clinicians must extend adequate support to accommodate their perspectives and views rather than contribute destructively.⁵¹³ On one hand, granted the MCA can be equally utilised by clinicians as personal narratives, which unearth the meaning underlying a behavioural pattern, it is critical to interpret mental process and can lead to independent

⁵⁰⁸ Wallang, *op. cit.* p.160.

⁵⁰⁹ Desiree Boughtwood and Christine Halse, 'Other than Obedient: Girls' Constructions of Doctors and Treatment Regimes for Anorexia Nervosa' (2010) 20 *Journal of Community & Applied Social Psychology* pp.92-93.

⁵¹⁰ Steven R. Hahn, Kurt Kroenke, Robert L. Spitzer, David Brody, Janet B.W. Williams, Mark Linzer, and Frank V. Degruy, 'The Difficult Patient – Prevalence, Psychopathology, and Functional Impairment' (1996) 11(1) *Journal of General Internal Medicine* pp.1-8.

⁵¹¹ Russell, *op. cit.* pp.584-585.

⁵¹² *Ibid.*

⁵¹³ *Ibid.*

recovery.⁵¹⁴ Conversely, the mental element is significantly deemphasized as sole reliance on meaning and reasoning emerges as a pathway to verify the mental state much to the scepticism of mental health practitioners.

There would always be uncertainty on the possibilities or odds of relying on meaning alone to daily deconstruct and understand the intricate nature of the human mind. Wallang however argues that the complex and changing nature of human minds, human relationship and the environment warrants a deeper meaningful interpretation although not to the total discard of scientific diagnostic processes.⁵¹⁵ In reality, it might appear logical to find a non-biased medium between Wallang (compounded doubts on how the MCA can stand alone in practice or reality) and Frankl's subjective emphasis on substantiating meaning at all cost. Wallang however goes a step further to deconstruct the interpretation of the meaning of the experience as an equal significant aspect of understanding the way an individual attaches to those experiences.⁵¹⁶ Improper interpretation of the experience as presented by the individual will cause a distortive understanding of their truth. It becomes evident that relying on the perspective of an individual's conscious account is the only valid interpretation of their experience rather than third party insights regardless of the commonality of their disorder.⁵¹⁷

When underlying and circumstantial factors are excluded and not acknowledged, 'meaning' is never explored. The *body proper* is not significant but the psychological or mental element is emphasised, well engaged and presented as the root of

⁵¹⁴ Wallang, *op. cit.* p.160.

⁵¹⁵ Wallang, *op. cit.* pp.157-159.

⁵¹⁶ *Ibid.*

⁵¹⁷ *Ibid.*

disordered behaviours. The body – physical component becomes merely an outcome or manifestation of the processes that occur within the mental experience. Understandably, the evolution of science is dependent on a comprehensive classification system; therefore alternate models that do not correlate with the scientific diagnostic and treatment catalogues are excluded by clinicians, effectively restricting the flexibility of applying models, which are not reflected in the standardised classification system. In considering the general approach in tackling mental diseases, little attention is given to instances where not only treatment fails either as a result of a factor beyond the control of the clinician or more significantly in the instance of deliberate decision of the patient to refuse treatment and assert their rights to liberty, autonomy and dignity. In the instance a changing perspective results in treatment refusal, such scenario immediately locks the clinician in an ethical and practical quagmire, which neither the clinician nor the statistical manuals had anticipated. Wallang expresses that certain behavioural patterns have become automated in a way that individuals lose conscious awareness.⁵¹⁸ This is impossible as every behaviour has an established origin processed through multitudes of thoughts, actions both negatives and positives, continuously dissected and reintegrated to establish the reality that forms the behaviour exhibited. For the medical model, it is easier to trivialize or reduce behavioural patterns to non-locomotive motions of unconscious behaviour and awareness, which projects the individual as unable to make decisions that can inform their choices and free will. The way an individual expresses their informed choices forms part of their narratives, the interpretation they choose to project whether through their physical body (resistant body) or otherwise represents a conscious awareness and acceptance of their

⁵¹⁸ *Ibid.*

experience. Higher reasoning whether negative or positive, which uncovers a deeper meaning, cannot be achieved by a subconscious mind or body. Granted, some experiences are not prominent as others, however the history of all experiences are not vague neither is the significant impact of each experience. Critical consideration should therefore be given to established historical trace of experiences through constant references throughout a person's lifetime. However, exploring those lived experiences are fundamental to establishing a pathway of tracing future actions which are unique to the individual thereby creating a significant link between the past and the present.⁵¹⁹ Invariably, a person's overall impression in life is reliant on the total composition of their narratives, therefore, only through individualised assessment of the accrued accounts can there be a full comprehension of "emotional component of that individual and develop a significant degree of meaning".⁵²⁰

The above analysis of the meaning centred approach leads to the question of why the significance of understanding, acknowledging and accepting the narrative of an individual is important in medico-legal system. First, there is established precedence where the reasoning behind an individual's disorder, conscious or not are not taken into account in treatment and commitment proceedings. Acknowledging that an individual can comprehensively give account of their reality through a narrative, which explains how they arrived at the behavioural pattern exhibited, is adverse to the standard medical and mental health practice. It could then be deduced that regardless of the physical or adjudged mental state of the individual, a conscious account considered or at best prioritized may bridge the gap between involuntary and voluntary treatment. Accepting that no decision or choice can exist without a

⁵¹⁹ *Ibid.*

⁵²⁰ Wallang, *op. cit.* p.159.

compressive and comprehensive synthesis of thoughts and experience validates the competence and capacity of the individual to refuse involuntary treatment and exercise their rights to autonomy.

Developing a framework that extends to the inclusion of individualised meaning within the medical framework of diagnosis is rare and unusual. Boughtwood and Halse, however, suggest the medical departure from the sole characterisation of anorexic by their behaviours and symptoms.⁵²¹ A meaningful dimension would rather foster the understanding of anorexia by utilising their vision and values by identifying that every anorexic is dissimilar and “... respecting the meanings they attached to their illness...”⁵²² The challenge for medicine is that accepting a new pathway that includes individualised meaning would represent an acknowledgement that the medical field do not have all the solutions for the underlying reasons why young women relentlessly succumb to self-starvation, thereby admitting the inadequacies of the present treatment route.⁵²³ Arguments in support of the MCA focus on the effective structure that allows for the emergence of personal narratives in interpreting a person’s experience in order to clarify the underlining meaning.⁵²⁴ Examining a practical example, Wallang notes that regardless of the questionable mental state, compounded by physical deterioration, the individual was able to engage effectively with their experiences through a personal narrative, which reflected his motivation and informed choices.⁵²⁵ The relevance of the MCA can become universal across genres with its application and meaning continuously evolving as it continuously adapts to multiple discourse. Banks therefore insists that in order to remove all

⁵²¹ Boughtwood and Halse, *op. cit.* pp. 89-94.

⁵²² *Ibid.*

⁵²³ *Ibid.*

⁵²⁴ Wallang, *op. cit.*

⁵²⁵ *Ibid.*

ambiguity and gain clarity on the underlying meaning of thinness and self-starvation “a meaning-centered studies of anorectics especially those in non-clinical settings-are needed to clarify the cultural contexts of the disorder”.⁵²⁶

Medical and science-based definitions and understanding of anorexia have always been prominent and dominant in any field of studies regarding eating disorders. The model by which individuals are accessed and evaluated is solely reliant on the understanding and meaning furnished through strict diagnostic criteria recognised by treatment professionals. In the case of anorexia, it is a straight-lined classification, diagnostic and treatment outcomes narratives with no scope to extend beyond the established practice or seek in-depth meaning. For decades, critics have alluded to other factors that contribute to the definition of many mental disorders. These highlighted factors such as experiences, culture, moral and values which are not acknowledged as core or integral in the development of any form of mental disorder. Wong notes that human beings are “by nature, meaning-seeking and meaning-making creatures who constantly make sense of their experiences in real life”.⁵²⁷ It, therefore, follows that in order to understand an unusual (abnormal) behaviour in an individual the meaning underlying such behaviour is critical in obtaining a well-rounded perspective. The individual’s voice becomes the first noted authority in their management and care. To secure an ideal portrait in the understanding of self-starvation, for instance, examining the intersection between extended frames in disciplines, amongst other factors, which recognises a person’s consistent attempt to validate their choices and affirm personal control. This process of inclusion and affirmation of personal control and choices underlines the doctrine of informed

⁵²⁶ Banks, *op. cit.* pp.867-884.

⁵²⁷ Wong, *op. cit.* pp.207-216.

consent. There is however no accurate or uniform portrait representative of the meaning-centred anorexic body experience. A broader individualised intersection of their immediate values and the next choices can be conceptually analysed within societal contexts to obtain a productive outcome. These cross-sections of multifactorial experiences or occurrences vary from isolated food restriction, distinctive weight calculation, and desperation to stay within a controlled scale size.⁵²⁸ The meaning-centred ideals transcend cultural metaphors directly manifested through self-starvation as a pathway to creating a socio-cultural or political revolution. For example, incorporating the values drawn from experiences would validate the free will and choice of the individual in the conscious restraint of the body without undue influence or coercion. Exploring the meaning anorexics give to their condition, Marzola, *et al* carried out a qualitative investigation into the condition anorexia nervosa. Their sample was made up of 34 anorexic patients.⁵²⁹ To achieve their goal, the researchers asked the participants to write a letter to their condition in which they should describe what the condition (anorexia nervosa) means to them. The outcome of their investigation revealed that the participants differed in the meanings they ascribed to their condition.⁵³⁰ Some of the participants felt protected by their condition, while others felt negatively towards it. For the latter, their lives were being wasted because of the condition.⁵³¹ They expressed anger, dependence, and hate towards their condition. Also expressed by this category were feelings of betrayal and being cheated by their condition. Those who claimed they felt protected by their condition seem to have false confidence and may starve themselves to the point of becoming

⁵²⁸ Hans-Christoph Steinhausen, 'The Outcome of Anorexia Nervosa in the 20th Century' (2002) 159(8) *American Journal of Psychiatry*, p. 1284.

⁵²⁹ Enrica Marzola, Giovanni Abbate-Daga, Carla Gramagha, Federico Amianto and Secondo Fassiono, 'A Qualitative Investigation into Anorexia Nervosa: The Inner Perspective' (2015) available at <https://doi.org/10.1080/23311908.2015.1032493> [accessed 5th April 2018].

⁵³⁰ *Ibid.*

⁵³¹ *Ibid*

physically ill and even fatality.⁵³² The expression of hate, anger, anxiety, despondence, depression, betrayal and even the false confidence of feeling protected by the anorexic condition are reflective of mental health problems.⁵³³

Historically, advocacy for freedom of choice, autonomy and consent of the anorexic body have been flawed by clinical impositions of treatment options to ease recovery. Regardless of the invasive treatment options to facilitate recovery, there is still a record of constant high mortality rate, low recovery, and distinctive treatment resistance.⁵³⁴ A *resistant body* is registered as non-consenting, therefore, lacking the capacity to contribute to the decision making process. The *resistant body*, therefore, has little or no say in treatment decisions and is not required to furnish their consent before treatment.⁵³⁵ Implementing a meaning-centred identification will enable an adaptive provision of personalised care and management for persons normalised in those actual patterns of abnormal or unusual behaviour regardless of the stiff labels dictated by the Mental Health Act. MCA to the studies of anorexia removes the rigid clinical approach and interpretation of thinness and self-starvation and amplifies both the social and cultural context. Within the meaning-centred variation, a clear demarcation can be made between the “*resistant body*” also known as the “*meaning-centered anorexic body*” and the classic “*patient-centred anorexic body*”. The patient-centred anorexic body is the overtly labelled individual created by the DSM to fit the mental disorder/insanity stereotype. The stereotyped body ceases to be an individual with any sense of self but a patient form fitted into the mould created by clinicians to

⁵³² *Ibid*

⁵³³ *Ibid*

⁵³⁴ Jacinta O.A. Tan, Tony Hope, Anne Stewart and Raymond Fitzpatrick, 'Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values' (2006) 13(4) *Philos Psychiatry Psychol.* pp. 267-272.

⁵³⁵ Kluge *op. cit.*

produce a specific outcome. A useful distinction between the *meaning-centred anorexic body* and *the patient-centred anorexic body* will address the compound debate of autonomy, consent, and capacity.

The meaning-centred anorexic body has precise knowledge and direction on choices evidenced in a clear, concise immediate or advanced decision and once presumptuous incapacity is eliminated, cannot be adjudged to lack capacity solely based on the general principles under the Mental Capacity Act 2005. There is a marked history of self-starvation, food refusal and extreme thinness transcending western clinical/medical ideologies. An in-depth cross-cultural analysis engages the cultural contexts of anorexia exclusively, embedded in their experiences and sustained through self-discipline, self-determination and assertion of bodily integrity and autonomy. Engaging the personal and underlying meaning of the anorexic body ensures that the choices, norms, values and decisions (meaning-centred) of the individual are hierarchical to the established presumptions surrounding mental disorder. It is, therefore, essential to analyse anorexia outside western bound syndromes and within cultures where anorexia nervosa is not recognised as a mental illness. Classic symptoms of anorexia (fear of weight gain, extreme thinness, self-starvation and food refusal) are symbolic to self-discipline and self-rule thereby breaking gender barriers, religious or cultural oppression. For instance, the established western beauty-ideal tall, thin and straight through hips is not appealing to men of African heritage. An analysis of the favoured body type of African-American men

and Caucasian revealed that African American men show preference and are "more accepting of larger sizes for women than Caucasian men".⁵³⁶

Lamb concludes that "being fat is a beauty ideal for much of Africa" and the fattened woman presents a way into the love, respect and heart of the man.⁵³⁷ The ideal West African woman is well endowed; the fuller and curvy woman is considered the apple of the man's eye and their bodies, possessions or assets of their husbands.⁵³⁸ Channel 4 unreported world documentary focused on West African nation of Mauritania revealed that the fat or chubby woman was regarded as the epitome standard of beauty every young girl must adhere to.⁵³⁹ Young Mauritania girls were then forced to eat 16000 calories a day in order to attain this standard of beauty set by the community. Girls with normal ranged BMI are this often-dangerous force-feeding process.⁵⁴⁰ The consumption of up to 16000 calories a day will not only enable these young girl gain the desired amount of weight but also prepare them to be more pleasing to male suitors. The feeding lasts for a minimum of two months at a time within which these young women are forced against their will to consume litres of camel milk, kilos of couscous and porridge.⁵⁴¹ The significance of fattening these young women is not only associated with the notion of beauty but also positive body image as desired by men and also a sign of wealth and affluence. Refusal to conform

⁵³⁶ Rachel E.K. Freedman, Michele M. Carter, Tracy Sbrocco and James J. Gray, 'Do Men Hold African-American and Caucasian Women to Different Standards of Beauty' (2007) 8(3) Eating Behaviors Journal p.319.

⁵³⁷ Lamb Christina, 'Eat, Eat, Eat if You Want to be Loved in Africa, Big is Beautiful' available at https://www.biyokulule.com/view_content.php?articleid=5554 [accessed 1st July 2019]

⁵³⁸ Sunday Standard, 'Who Defines African Beauty?' available at <http://www.sundaystandard.info/who-defines-african-beauty> [accessed 16th October 2018].

⁵³⁹ Daily Mail, 'The West African Nation Where Girls are Forced to Consume up to 16,000 Calories a Day by their Mothers during 'Feeding Season' – to make them 'Beautiful for Men' available at <https://www.dailymail.co.uk/femail/article-6468637/African-girls-young-ELEVEN-force-fed-16-000-calories-day-make-fat.html> [accessed 18th January 2019].

⁵⁴⁰ *Ibid.*

⁵⁴¹ *Ibid.*

to the feeding regimen will attract detention, physical restriction, physical abuse and force-feeding.⁵⁴² According to Ghosh, "most women of Ghana shun the emaciated figures of fashion models and believe that being "full figured" denotes not only attractiveness but as good health and prosperity".⁵⁴³ In Nigeria, the Urhobo woman is the standard of beauty, fat, fleshy, big, curvy and voluptuous. Cultural practices in Calabar (Southern Nigeria) mandates girls as young women to be "fattened up" before they are married.⁵⁴⁴ The long-standing tradition of the Efik tribe guarantees that a woman is sent to the fattening room where she is isolated from her village, removed from any physical activity and made to eat as much as she can against her will. The fattening process also includes ensuring her hips are broadened for reproduction. The female body, therefore, implies desirability; her value is in being a suitable pick for a wife, vessel for reproduction and catering to the needs of the man. When the body is objectified, weight loss or weight gain remains adapted to the self-serving interests and control of the male gender. Self-starvation, food refusal or adopting the resistant meaning-centred anorexic body for these women within a repressive cultural environment is regarded as a sign of rebellion against established and entrenched misogyny. New feminine ideal of beauty is created by consciously and voluntarily adopting the meaning-centred body as a feminist symbol of liberation, emancipation and control. In many ways, the meaning-centred anorexic body therefore consciously and voluntarily engages self-starvation and thinness as a symbol of self-determination, autonomy and control over their body and self. The distinctive feature of the meaning centred anorexic body is embedded within the cultural contexts of

⁵⁴² *Ibid*

⁵⁴³ Palash Ghosh, 'The Fat of the Land: Western Standards of Beauty Clash with West African Notions' (2012) available at <http://www.ibtimes.com/fat-land-western-standards-beauty-clash-west-african-notions-843573> [accessed 28th September 2019]

⁵⁴⁴ British Broadcasting Corporation, The Fattening Rooms of Calabar available at <http://news.bbc.co.uk/1/hi/6904640.stm> [accessed 13th August, 2019]

meaning, morals, and experience but also in the cognitive acknowledgement and recognition that there is no desire to starve to death or commit suicide as established and recorded in cases such as *A NHS Foundation v Ms X*.⁵⁴⁵ It is impossible not to acknowledge that the demographic of the patient-centred anorexics do not embrace self starvation as a symbol of resistance rather they are not only suicidal but preoccupied with the mere physical aesthetics of thinness and physical emaciation as highlighted in *Re (E (Medical Treatment Anorexia))*.⁵⁴⁶

The patient-centred anorexic body engages in food refusal, self-starvation and body weight management with no clear, precise meaning or concept to their self-starvation. The meaning-centred anorexic body is subjectively dissimilar; the standard pattern of behaviour addresses an individualised norm, symbolic to self, culture, morals and experience.⁵⁴⁷ It is, however, critical to investigate further if the meaning-centred anorexic body can lead a conceptually normal life within a controlled weight devoid of any attempt to end their life. All behavioural aspects must reveal distinguishable traits from a non-meaning centred anorexic. Hence, the author's disagreement with Crisp's insistence that all anorexic bodies possess diminished rights of independence and exhibit immaturity in leading a normalised life.⁵⁴⁸ Lending to a better understanding of the meaning-centred anorexic body, a cross-cultural analysis reveals that the Mental Health Act and policies in Nigeria do not recognise anorexia nervosa as a mental illness. In-depth information or knowledge linking anorexia nervosa to mental illness is therefore non-existent comparative to the reinforced stereotype of the UK Mental Health Act 1983 which classifies anorexia nervosa as a mental illness,

⁵⁴⁵ *A NHS Foundation Trust v Ms X* [2014] EWCOP 35.

⁵⁴⁶ *Re E (Medical Treatment Anorexia)* [2012] EWHC 1639 (COP).

⁵⁴⁷ Banks, *op. cit.* pp. 867-884.

⁵⁴⁸ Arthur H. Crisp, 'Anorexia Nervosa at Normal Body Weight: The Abnormal Weight Control Syndrome' (1981) 3(11) *International Journal of Psychiatry in Medicine* p.204

which must be treated involuntarily. Such justification of paternalistic intervention is without consideration to the perils of involuntary treatment as a direct violation of personal autonomy, removing their rights to make informed choices without being unduly influenced or coerced.⁵⁴⁹

Suggestions that the traditional settings of human rights do not apply in non-western cultures are adrift. Largely, it acknowledges that the disparities in human rights obligations are prominent. Other cultures may seek to embrace their values of human rights in a less theoretical way different from western understanding of rights as programmed by a charter, legislation or -byelaws. In Nigeria, for instance, it is repeatedly observed that human rights are personal; the value attached to autonomy is non-conformist to universal expectation. The language in rural, non-industrial towns reflects the individualism and autonomy they embrace while resisting own oppressive system. This research looks at anorexia nervosa from a meaning-centred perspective highlighting the meaning and reasoning behind the experience of self-starvation, which excludes mental illness. Most women one way or the other go through the course of exerting control over their body concerned about weight gain at some point during their lifetime.⁵⁵⁰ The meaning or reason behind adopting a meaning-centred anorexic body is dependent on a variety of factors, which includes the individual's current situation, projected future encounters, and experiences, which supersede traditional medical concepts. Take for instance a prospective bride who in addition to excessive exercise is also self-starving for weeks to fit into a wedding dress. The calorific restriction at that point is symbolic and meaning-centred on achieving the

⁵⁴⁹ Jill A. Matusek and Margaret O. Wright, 'Ethical Dilemmas in Treating Eating Disorders: A Review and Application of an Integrative Ethical Decision-making Model' (2010) 18 *European Eating Disorder Review* p.436.

⁵⁵⁰ *Ibid*

smaller body size for the wedding day. This behaviour permits the bride the freedom to influence her body in a manner confined with a scale limit. The specific knowledge that food restriction is limited to a few months or years is sufficient to create a consciousness dissimilar to the patient-centred anorexic body as postulated under the Mental Health Act. A meaning-centred anorexic body is unambiguously assumed to reflect a particular or series of experiences and personal identity of the individual. Excessive exercising, dieting, calorie counting and restrictive eating play fundamental roles, which lead to the desired physical emaciation and thinness. In retrospect, the meaning-centred anorexic body exhibits competence and is knowledgeable of the way their body develops and thereby formulates a criterion that moderates and manages this construction. This body manifests in a restricted construction dependent on the essential and exclusive presentation of the body as having choice and direction. The Nigerian dimension is critical and timely as no laws classify anorexia nervosa as a mental illness. Therefore, individuals can exercise the freedom and autonomy over their body and subject it to control without the stereotype of mental illness or fear of subjection to involuntary treatment.

CHAPTER FOUR

Meaning-Centred Anorexic Body

4.

The previous chapter introduced the application of the meaning-centred approach as significant in broadening the obligation to recognise other independent settings and alternative concepts that recognise the experiences, values, morals and decisions of the anorexic body. Within the meaning-centred framework, an extended conceptual analysis will ensure that several unusual characteristics of a mentally ill person are shared across cross-cultural borders of meaningful illness. Standard of rationality in cross-cultural meaning establishes that the level of competency is distributed within an existing autonomy enhancing setting, so the individual's right is in place regardless of the scientific or medical diagnosis. This present chapter introduces the theoretical analysis of the meaning centred anorexic body by introducing a legal dimension to identifying a voluntary creation, resistant to paternalistic control as the body moves away from the universal attraction and acknowledgement as a docile object that needs to be institutionally regulated, disciplined, and subjected to punishment.⁵⁵¹ Drawing upon the evolving legal and ethical norms, this chapter addresses the need for recognition of the values of autonomy, which the anorexic body clings to for self-determination and expression.

⁵⁵¹ Foucault, op. cit. 136.

4.1 Critical Analysis

Laségue and Gull facilitated the earliest glimpse into the nature and complexities of anorexia nervosa.⁵⁵² Anorexia nervosa has become extensively researched and literature in this area reveals association among the variables – self-starvation, food refusal, excessive exercise and mental illness.⁵⁵³ Accordingly, medical analysis of anorexia points out that individuals with eating disorders have extreme weight concerns and considers food as the enemy. For clinicians, the anorexics food phobic nature is regarded as a reflection of their overall mental state. Food denial therefore represents not only an altered mental and cognitive function but also physical disability as the anorexic body succumbs to the side effects of self-starvation. Glover-Thomas, a treatment gastroenterologist, conventionally labelled the patient centred anorexia as severe, misinterpreted, extraordinarily rare, relentless in nature and destructive.⁵⁵⁴ Research reveals that despite various clinical impositions to facilitate the recovery of anorexic patients; there is still a record of constant high mortality rate, low recovery, and consistent treatment resistance.⁵⁵⁵ In Glover-Thomas' opinion, anorexia nervosa symptoms are buried deep, unusual, and not subject to traditional medical detection.⁵⁵⁶ The various highlighted symptoms of anorexia nervosa are constructed on the premise that the standard functionality of the body is dependent on food consumption. Thus restricting the human body from indulging in what it craves disrupts that part of the brain hypothalamus,⁵⁵⁷ thereby creating a sense of anxiety,

⁵⁵² Sara Valente, 'The Hysterical Anorexia Epidemic in the French Nineteenth-Century' (2016) 9(1) *Dialogues in Philosophy, Mental & Neuro Sciences* available at <http://www.crossingdialogues.com/Ms-A16-02.pdf> [accessed 8th April 2019] pp.22-23.

⁵⁵³ Emily Davenport, Nola Rushford, Siew Soon and Cressida McDermott, 'Dysfunctional Metacognition and Drive for Thinness in Typical and Atypical Anorexia Nervosa' (2015) 3(24) *Journal of Eating Disorders* pp.1-2.

⁵⁵⁴ *NHS Trust v L* [2012] EWHC 2741 (COP) para.1–15.

⁵⁵⁵ Tan, *et al*, *op. cit.* pp. 267–272.

⁵⁵⁶ *Ibid.*

⁵⁵⁷ Erlanson-Albertsson, *op. cit.*, pp.66-73.

guilt, and self-loathing and in most cases depression. Consequently, radical deterioration is thought to be inevitable due to the chemical imbalance of the body and brain as a whole.⁵⁵⁸

Section 307.1 of the DSM-5 defines anorexia nervosa as a mental disorder.⁵⁵⁹ Anorexia nervosa is a form of eating disorder characterised by a refusal “to maintain a minimally normal body weight”, extreme fear of weight gain and a significant distortion of the true nature and perception of the body or size of their body.⁵⁶⁰ The DSM-IV further explains that anorexia nervosa is reinforced through “dieting, fasting and excessive exercise as a means of weight control or weight loss”.⁵⁶¹ The guideline established for clinicians to detect anorexia suggests a benchmark based on 17.5% body mass index or “less than 85% of the weight that is considered normal for that person’s age and height”.⁵⁶² The anorexic restrictive feeding pattern differs from other forms of eating disorders characterised by frequent episodes of binge eating and purging (bulimia) to stimulate weight loss. William Gull facilitated the earliest glimpse into diversified and alternate models of evaluating and analysing the complexities of anorexia nervosa.⁵⁶³ Suffice it to say, the typical response to anorexia nervosa before Gull was insouciant and nonchalant. In a presentation before the annual meeting of the British Medical Association in Oxford, Gull, a medical physician, referred to the condition as *Apepsia Hysterica* later amended to *Anorexia Nervosa* in a report to the clinical society and the medical Gazette in 1873.⁵⁶⁴ Gull

⁵⁵⁸ *Ibid.*

⁵⁵⁹ DSM-IV, *op. cit.*, 307.1

⁵⁶⁰ *Ibid.*

⁵⁶¹ *Ibid.*

⁵⁶² DSM-IV, *op. cit.*, pp.539-540.

⁵⁶³ *Ibid.*

⁵⁶⁴ Antoni Niedzielski, Natalia Kazmierczak and Andrzej Grzybowski ‘Sir William Withey Gull (1816-1890)’ (2017) 264(2) *Journal of Neurology* pp.419–420.

characterised anorexia nervosa by physical emaciation, which occurs without any apparent or visible cause – excluding the mental element.⁵⁶⁵ The various highlighted symptoms of anorexia nervosa was then constructed on the premise that the standard functionality of the body is dependent on food consumption, restricting the human body from indulging in what it craves, disrupting that part of the brain hypothalamus,⁵⁶⁶ thereby creating a sense of anxiety, guilt, self-loathing and in most cases depression. Consequently, radical deterioration is thought to be inevitable due to the chemical imbalance of the body and brain as a whole.⁵⁶⁷

A significant research document published by the World Health Organization (WHO) on the International Classification of Diseases reveals obvious symptoms of anorexia. For most people, the key indicator is a refusal to maintain a healthy body weight ratio because of the morbid fear of weight gain.⁵⁶⁸ Many adopt a pattern of full starvation as a coping mechanism.⁵⁶⁹ These symptoms include a drastic reduction in body mass index (BMI), retaining an unhealthy BMI, which leads to at least 15% below the normal or expected weight for age and height. Notable symptoms according to the WHO's document include suppression of food intake, morbid fear of weight gain by systematic avoidance of high-fat content foods, presumed to enable any form of weight gain and the limitation of the quantity of food intake. There is also the elimination of food already consumed by resorting to the overuse of diuretics and laxatives to maintain the already low BMI already achieved by starvation, over-

⁵⁶⁵ *Ibid.*

⁵⁶⁶ Charlotte Erlanson-Albertsson, 'How Palatable Food Disrupts Appetite Regulation' (2005) 97(2) British Journal of Clinical Pharmacology pp.66-73.

⁵⁶⁷ *Ibid.*

⁵⁶⁸ Christine Halse, Anne Honey and Desiree Boughtwood, *Inside Anorexia: the Experiences of Girls and their Families* (London, Jessica Kingsley Publishers 2008). pp.16-17.

⁵⁶⁹ *Ibid.*

exercising, and limitation of food intake.⁵⁷⁰ Understandably, clinical interpretations of anorexia nervosa focus on physical emaciation and the biological patterns of the individuals suffering. There is also a primary reference to unique key additive personality traits such as perfectionism and obsessive compulsory behaviour. Medical and psychiatric intervention, therefore, laid radical emphasis on the negative impact of this deterioration to the brain, which causes an imbalance in hormones, impelling the individual to develop more abnormal behavioural obsessiveness in both pattern and practice.⁵⁷¹ Predominantly, establishing any of these symptoms or behavioural trends in full or part leads to a presumptuous involuntary treatment entirely focused on normalising eating patterns and preservation of life. With the diagnosis of anorexia nervosa established, medical intervention is initiated to impose treatment that aids physical recovery. To medical practitioners, this critically low body weight necessitates involuntary re-feeding in the hospital to reverse biological consequences of starvation.⁵⁷² Medical treatments are, therefore, administered towards curing the biological or physical conditions that develop because of self-starvation rather than tackling the psychological aspects.⁵⁷³

At first glance, anorexia nervosa discourse appears to be a matter for the clinical entity with its distinct features scientifically documented over an extended period.⁵⁷⁴ However, most recently, interest in anorexia has transcended cultural borders,

⁵⁷⁰ World Health Organization (WHO), ICD- 10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research available at <http://www.who.int/classifications/icd/en/GRNBOOK.pdf#p135> [Accessed 4th Dec. 2013] p.135.

⁵⁷² Rosalyn Griffiths and Janice Russell, 'Compulsory Treatment of Anorexia Nervosa Patients' in Walter Vandereycken, Pierre J.V. Beumont (eds.) *Treating Eating Disorders: Ethical, Legal and Personal Issues* (London, Athlone Press 1998) p. 139.

⁵⁷³ *Ibid.*

⁵⁷⁴ Daniel L. Grange, 'Anorexia Nervosa in Adults: The Urgent Need for Novel Outpatient Treatments that Work' (2016) 53(2) *Psychotherapy Journal* p. 251.

expanding to non-clinical genres and offering a multidisciplinary approach to the understanding and interpreting the disorder. Intense research across multiple genres has spearheaded a unique unstructured engagement and understanding of the multiple facets of anorexia outside the strict discipline of medicine and psychiatry. Largely, the newly found interest is mainly attributed to the heightened objective to engage in a conceptually liberal analysis of the disorder beyond the biological symptoms. Crisp argues that anorexia only exists as a biological illness and considering any underlying psychodynamic actors will offer nothing new to the discourse.⁵⁷⁵ Contrariwise, biological analysis of anorexia has produced no new knowledge despite the constant publication of thousands of repetitive texts dissecting the biological structure and emaciation of the anorexic body. New studies in areas such as culture, media and feminism have offered a fresh perspective in understanding aspects of anorexia previously untouched. MacSween notes that it is insufficient only to acknowledge the biological aspects of anorexia nervosa.⁵⁷⁶ Extending the understanding beyond the biological symptoms provides the clarity to engage the anorexic body beyond the visible body functions but as an active participant in that creation.⁵⁷⁷ The significance of the emerging dimensions of the multifaceted nature of anorexia is often overlooked and downplayed. By all accounts, as the practical dynamics of understanding the natural outcome of anorexia change, so do the social, ethical, and contextual implications. There is, however, a reluctance by experts in the field of medicine and psychology to engage a broader perspective that recognises the controlled and voluntary patterns of the anorexic behaviour. As a voluntary participant, the meaning and core experiences of the anorexic body are acknowledged and interpreted in ways

⁵⁷⁵ Arthur. H. Crisp, *Anorexia Nervosa: Let Me Be* (East Sussex, Routledge 1995) p.6

⁵⁷⁶ Morag MacSween, *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa* (Abingdon Routledge 1995) p. 38.

⁵⁷⁷ *Ibid.*

that transcend psychological or biological statistics.⁵⁷⁸ The meaning-centred construction extends beyond the boundaries of the strict definitions of mental disorder stipulated in the DSM-IV and International Classification of Diseases (ICD), especially concerning intentional self-harm and starving to death. In the absence of intentional self-harm, pain or death, the values of the anorexic experience become prominent thus enabling the recognition of the individualised meaning and further acceptance of the autonomous rights of the individual.

The pathway to the modern construction of the anorexic woman is one marked with increased loneliness as the body transitions from a physical organism into a concept.⁵⁷⁹ In this transition, many individuals recount stories of incorrect labelling, isolation, and ostracising by society, family, and friends. Thus, the complex psychological world of anorexia is riddled by defects in information and belief, with no actual evidence to support them. Searching for ethical answers, which support the many stereotypes will occasion a chain of moral doubts. There is no question that misconceptions and prejudices dominate the overall understanding of anorexia with no significant relevance or awareness of the several layers of the disorder. Treatment practitioners often embraced myopic views of predominantly relying on the manifestation of a set of physical symptoms' to shape or define the capacity and treatment response. Adopting the stereotypical stance, therefore, prevents any engagement in variations of concepts outside the confines of medicine and psychiatry.

Current treatment and care approaches do not present personalised views reflective of the experiences and values of the anorexic person. Historically, arguments for

⁵⁷⁸ *Ibid.*

⁵⁷⁹ MacSween, *op. cit.*, p.24.

individuality, freedom of choice, autonomy, and consent of the anorexic body have been flawed by stereotypical misconceptions. The anorexic body is therefore already disadvantaged, as initial assessments for treatment are profoundly dependent on predetermined factors, without considering the unique values, morals and choices of the individual. In fact, Crisp once noted that: “ immediate and striking clinical feature is usually emaciation. The anorexic is just thinnish person, small boned but fully formed; she is skeletal in appearance”⁵⁸⁰ Crisp, unsurprisingly, also fails to look beyond the biological elements to engage a more conceptual analysis. The conclusion that anorexia nervosa is an illness that can be identified “often at a glance” at the individual’s diminishing physical appearance⁵⁸¹ strengthens the medical criteria for justifying a patient-centred psychodynamic treatment where the person makes little or no contribution in arriving at their treatment or care decisions.⁵⁸² Resistance to therapies meant to cure the associated physical ailments only enhanced the psychiatric justification for such involuntary intervention.⁵⁸³ Crisp further refers to anorexia as a “disorder of the affluent and westernised society”.⁵⁸⁴ Like several other writers, Crisp, a psychiatrist, derived his conclusion from a small pool of anorexic individuals under his care rather than the wider variation of individuals who do not fit the *status quo*. Crisp’s perceptions are limited in this regard. It is apparent that there are more concrete values to be interpreted in the reasoning behind voluntary self-starvation, which transcends the confines of the middle class and affluent. Cynthia Bulik enunciates that the anorexic body is not mutually exclusive as ‘they cut across lines’,

⁵⁸⁰ Crisp. *op. cit.* p.11.

⁵⁸¹ *Ibid.* p. 5.

⁵⁸² Kluge, *op. cit.*

⁵⁸³ Carney Terry., Ingvarson Mim & Tait David., ‘Experiences of ‘Control’ in Anorexia Nervosa: Delayed Coercion Shadow of Law, or Disseminated Power and Control?’ in Pamela Swain (ed.), *Anorexia Nervosa and Bulimia: New Research*. (New York, Nova Science Publishers Inc 2006) p. 55.

⁵⁸⁴ Crisp. *op. cit.*, p. 5.

from upper to middle and low middle class and from teenage girls to adults alike. It affects all ages, races, and social classes.⁵⁸⁵

Unchecked assumptions, prejudices, and stereotypes contribute to social ostracism, which can violate or constitute part of the rights violations faced by the anorexic body.⁵⁸⁶ Take for instance William Gull's views on anorexia as an 'occurrence with no visible cause' places emphasis on the involuntary nature associated with mental disorder especially the generalised presumption that mentally disordered individuals lack consciousness and awareness of the disorder and are unable to consent voluntary actions. Using Gull's definition will denote that there is no fundamental meaning to the element of physical emaciation, resistance to maintaining an average body weight and the intensive pursuit of thinness. It furthers the generalised assertion that the anorexic body is severely impaired and such impairment are sufficient to alter a person's better judgment in making treatment decisions. According to Glover-Thomas, the nature of the psychiatric illness has impaired the way the brain and mind function, leaving the sufferer with an exaggeration of her exact body proportion or shape.⁵⁸⁷ This portrayal of having diminished competence weakens the grandstanding to assert the right to refuse or accept medical treatment as it ultimately questions 'the ability of the patient to make reasonable decision'.⁵⁸⁸ Diminished competence, therefore, automatically disqualifies an individual from utilising the information presented to them in order to make the best clinical decision. This representation depicts the person as non-functional, irrational, devoid of normalcy and, therefore,

⁵⁸⁵ National Institute of Mental Health available at <https://www.nimh.nih.gov/news/media/2014/eating-disorders-myths-busted-myth-5-eating-disorders-are-the-province-of-white-upper-middle-class-teenage-girls.shtml> [accessed 14th June 2019].

⁵⁸⁶ Weiss, *op. cit.* p. 2.

⁵⁸⁷ *NHS Trust v L* [2012] EWHC para 5.

⁵⁸⁸ Raphael J. Leo, 'Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians' (1999) 1(5) Primary Care Companion Journal of Clinical Psychiatry p.131.

unable to fulfil their day-to-day roles.⁵⁸⁹ To the contrary, overwhelming evidence identifies most anorexic individuals as bright, functional and intelligent even at the most critical stages of diminished physical or mental state.⁵⁹⁰ In various instances, the anorexic body has proven to be intellectual, rational in understanding, able to retain the information presented to them and often very skilled. Charles Scott notes that if an individual is deemed incompetent in one area of life does not mean competence is lacking in all spheres.⁵⁹¹ Scott notes that even if mental disorder is established, that does not prove incompetence. Invariably “even a severely mentally ill individual may be competent; in so far as the symptoms of their illness do not impact the areas of mental functioning required to be competent”.⁵⁹² Giordano insists that the general principle of autonomy under the United Kingdom laws does not support the conception of the assumption that the diagnosis of a mental illness in any way equates or projects incompetence; however, it should provide the basis to “investigate further her capacity to consent”.⁵⁹³ It becomes very problematic to assume that once a person is diagnosed with an eating disorder and refuses treatment, she is automatically incompetent to make medical decisions. A logical protest reaction will finger the eagerness of clinicians to perpetuate the impression of helplessness, vulnerability, and incompetence of the anorexic body to further their agency and justify unconsented paternalistic intervention. One may assess competence-relative degree of functionality regardless of the physical state of emaciation – for instance, holding a job, excelling academically, making advanced decisions and plans for the future and most importantly the lack of desire or plan to die or inflict self-harm intentionally.

⁵⁸⁹ *Ibid.*.

⁵⁹⁰ *Ibid.*.

⁵⁹¹ Charles L. Scott, *DSM-5 and the Law: Changes and Challenges* (Oxford, Oxford University Press 2015) p.102.

⁵⁹² *Ibid.*.

⁵⁹³ Giordano. *op. cit.*, p.193.

One might argue the relevance of conducting the task of understanding and engaging the little intricacies of an anorexic body. Why elucidate the little details surrounding anorexia? One must understand that there is a wealth of information provided by the ‘smallest fragments of life and the body’.⁵⁹⁴ Vintage and modern structuralism allude to the notion that greater meaning lies in the connections of the element underneath the surface. It is an autonomous system, which reveals the reason behind a person’s action, an essence that transcends its appearance.⁵⁹⁵ Those little experiences, emotions, and feelings exhibited by the anorexic body count towards the bigger picture of understanding their values, who they are, why they behave a certain way, and, most importantly, the motives behind every action.⁵⁹⁶ It will become evident throughout this work that the author deliberately refrains from referring to a meaning centred anorexic body as a patient. The analysis is consistent with the voluntary actions of the anorexic body in maintaining a controlled weight without the intention of death, suicide or intentional self-harm. For instance, the blurred line between the meaning centred anorexia and the patient focused anorexia compounds the debate on consent and capacity.

Traditionally, women are more body objectified than the male counterparts. It is well documented that the female gender is susceptible to maintaining a thorough caloric restrictions, constant exercise and purging. Woodward notes that the size and shape of the body have progressively become “a symbol for the emotional, moral or spiritual state of the individual”.⁵⁹⁷ The newfound feminine projection of personal freedom and

⁵⁹⁴ Foucault, *op. cit.*, p. 140.

⁵⁹⁵ Allison Assiter, ‘Althusser and Structuralism’ (1984) 35(2) British Journal of Sociology p. 284.

⁵⁹⁶ Foucault, *op. cit.*, p. 140.

⁵⁹⁷ K. Woodward, *Identity and Difference* (London, Sage Publications 1997) p.170.

public empowerment is, therefore, valued as the result of the nascent connection between self-management and thinness.⁵⁹⁸ Considering that excess body weight has become synonymous with lack of strong will and personal inadequacy.⁵⁹⁹ If therefore it is important that the anorexic body involuntarily feeds, is it not as important to enforce involuntary mechanisms that can stop an overweight or obese person from constant eating? Particularly since most obese individuals do not conform to the practice of self-mastery, control and moderation and are susceptible to death or permanent impairment. The standard definition of anorexia accepted in medicine, psychiatry and law acknowledges the morbid fear of weight gain and restrictive eating as essential components of the disorder. However, restrictive eating, exercising and various forms of dieting form part of the day-to-day experience of most women in today's modern society. These behavioural patterns are easily identifiable in a demography of women conscious and willing to exist in a restrictive body weight. Statistics show that most women have a conscious fear of gaining weight and thereby devote a considerable amount of time on diets, exercising and particular controlled feeding patterns. There are numerous reasons every year for the female body to succumb to food restriction. The rest of the female body in today's modern society exists within the personal choices and autonomy constructed with meaning, choice and voluntary action. The most common consciousness or voluntary action is often in preparation for a memorable day such as birthdays, anniversaries, weddings or the millennial well-publicised summer body goals. The common connotation of anorexia is reflective and relevant in the choices of these women who exist outside the confinement and strict criteria of both medical and psychological disciplines. To generalise the definition of anorexia will imply that most women exist with some

⁵⁹⁸ Bordo, *op. cit.*, p. 212.

⁵⁹⁹ Susan Bordo, 'Reading the Slender Body' in Sue Thornham, Caroline Bassett, and Paul Marris, (eds.) *Media Studies: A Reader* (New York, New York University Press 2009) p.333.

form of anorexia, which is not interpreted or recognised within the domains of medicine, psychiatry or law. Establishing the characteristics of anorexia, the DSM-IV noted that:

“Usually weight loss is accomplished primarily through reduction in total food intake. Although individuals may begin by excluding from their diet what they perceive to be highly caloric foods, most eventually end up with a very restricted diet that is sometimes limited to only foods. Additional methods of weight loss include purging (i.e., self-induced vomiting or the misuse of laxatives or diuretics) and increased or excessive exercise.”⁶⁰⁰

Generally, emaciation is the aftermath of the various processes, which are considered anorexic behaviour. Most women in one way or the other go through the course of exerting control over their body concerned about weight gain at some point during their lifetime. The meaning or reason behind adopting a meaning centred anorexic body depends on varying factors which include the individual’s current situation, projected future encounters and experiences which supersede traditional conventions. A critical analysis of the judgment delivered by Mrs Justice King in *NHS Foundation Trust v L* implied that L a 29-year old woman exhibited traits of a meaning-centred anorexic body having not given the courts any cause to doubt her desire to continue to live and has progressively continued to make plans towards her future.⁶⁰¹ Bridget Dolan who represented the NHS Trust noted that despite the premonitions and

⁶⁰⁰ DSM –IV, *op. cit.*

⁶⁰¹ NHS Trust v L [2012] EWHC 2741 (COP).

labelling of L as ready to die, she has continued to live a balanced, controlled life in a lower weight.⁶⁰² It has also become evident that L can function within a cognitive state of dignity and autonomy without the reinforcements of clinical interference as such reasonable steps must, therefore, be taken to gain voluntary cooperation without force. It is clear that L's decision to remain at that weight is more significant in ways that exclude suicide and death. Otherwise, clinical adherence to continuously pursue the involuntary treatment route, motivated by the need to keep the person alive, will remain relevant and capacity to refuse treatment will continue to be prejudiced. The distinctive feature of the meaning centred anorexic body expresses autonomy within an individualised conception of purpose, morals, values and experience, in addition to admitting and proving that there is no intention to starve to death or commit suicide. In direct contrast to the position in *X vs. NHS*, X attempted suicide multiple times and exhibited no desire to continue to live.⁶⁰³ The non-meaning centred anorexic body engages in dieting and body weight management with no clear, precise meaning or concept to their self-starvation. The meaning centred anorexic body is subjectively dissimilar; their standard pattern addresses an individualised norm, symbolic to self, culture, morals and experience.⁶⁰⁴

It is therefore impossible to deny that a particular demography of anorexics are not only preoccupied with the mere physical aesthetics of thinness and physical emaciation without recognising the cognitive purpose or value. The severity of the consequences of food refusal in cases such as *NHS Trust v X* and *A Local Authority v*

⁶⁰² *Ibid.*

⁶⁰³ *NHS Trust v X* [2014] EWCOP 3

⁶⁰⁴ Banks, *op. cit.* pp. 867–884.

*E*⁶⁰⁵ are the extreme outcomes for patient centred anorexia. For instance, in *NHS Trust v X*, the physical symptoms that developed alongside X's anorexia were critical. X suffered from acute renal failure, liver failure (relating to alcohol abuse), multiple organ failures (which made her unconscious), jaundice, abnormal clotting of blood, encephalopathy, and variceal haemorrhage⁶⁰⁶. In addition, in *A Local Authority v E*,⁶⁰⁷ the anorexic patient developed an impaired liver, a compromised bone marrow that drastically reduced her resistance to infection, aspiration pneumonia, tuberculosis, and muscle/renal malfunction due to end-stage organ damage.⁶⁰⁸ These biological and physical outcomes are not comprehensive reflection of the experiences of the average patient centred anorexia. The professional obligation of clinicians means they cannot ignore the presence of critical physical symptoms that develop alongside a patient's illness. It is, therefore, understandable as to why medical professionals are more concerned about dealing with the physical consequences of starvation, which are severe, rather than focusing on the patient's rights or choices. Although anorexia can be chronic and threatening for some; however, some can live day-to-day without experiencing the life shortening severity of the illness.⁶⁰⁹ The one glove fits all treatment approach employed by clinicians is, therefore, problematic, especially as the disorder is such that every individual's experience is different, and so is the outcome. To be misguided in the interpretation and understanding of the illness will only enhance the psychiatric agenda of continuous implementation of involuntary and unconsented procedures. Clinicians are inclined to believe that treating the underlying cause of the anorexia (which, in this case, can involve multiple reasons) will relieve the physical conditions developed, however arriving at a balanced treatment option

⁶⁰⁵ *A Local Authority v E*, [2012] EWHC 1639 (COP) WL.

⁶⁰⁶ *NHS Trust v Ms X* [2014] EWCOP 35. para .23.

⁶⁰⁷ *A Local Authority v E* [2012] EWHC 1639 (COP) WL.

⁶⁰⁸ *Supra*.

⁶⁰⁹ Marilyn Lawrence, *The Anorexic Experience* (London, Women's Press Handbook 1998) pp.11–12.

that incorporates the choices and values of the individual have proven problematic.⁶¹⁰

As expected, the experiences of one anorexic body are very different from the other. Clinicians are yet to implement a flexible framework angled towards projecting an individualised view of the experience. Ideally, individualised variations to an illness are most likely not up for further consideration. Logically, clinicians are trained to accurately identify traits of an illness and broadly classify them into very specific categories. However, this approach consistently fails to cater for the multiple facets not recognised or accounted for by clinicians. Considering the complexity and multifaceted nature of anorexia, it is not far-fetched to raise very poignant deliberation on deconstructing the meaning-centred anorexic body as a ‘distinct entity’,⁶¹¹ excluded from the general Mental Health Act ceremonious classification of mental disorders. Legitimate consolidation comes from the absence of scientific proof of the presence of an underlying biological abnormality in the brain as recorded in other types of mental illness. There is also the scientific understanding, which reveals that anorexia nervosa has no similarity with extreme psychiatric conditions, such as schizophrenia, characterised by psychotic disturbances such as hallucinations and delusions.⁶¹²

Brunch notes that individuals have demonstrated several variations of self- control by food restriction over centuries. The most prominent are religious traditions that equate self-starvation as symbolising the cleansing of the body and mind from worldly

⁶¹⁰ Crisp, *op. cit.*, pp. 3-8.

⁶¹¹ David M. Garner and Paul E. Garfinkel, ‘Socio-Cultural Factors in the Development of Anorexia Nervosa’, (1980) (10) *Journal of Psychological Medicine* p. 647

⁶¹² Simona Giordano, *Conceptual and Ethical Issues in the Treatment of Anorexia Nervosa and Bulimia Nervosa* (Oxford, Clarendon Press 2005). pp.25-26.

desires.⁶¹³ Bordo considered self-starvation was a significant aspect of the Christian faith in the middle ages. The ritual of fasting primarily emphasises renouncing the demands of the flesh (physical body) whilst offering spiritual cleansing to select elites and aristocrats considered privileged of such spiritual distinction. Variations of diet was seen as an instrument of self-development and uplifting of the inside being in order to achieve excellence.⁶¹⁴ There are also biblical references to self-starvation as a means to atone for sins or receive a fulfilment of a promise or blessing from God. When faced with adversity, Queen Esther commanded her uncle Mordecai and his fellow Jews to deprive themselves of food and drink for three days and three nights.⁶¹⁵ For Queen Esther, self-starvation was not only an expression of selfhood but also a religious symbol of courage, strength, and determination before approaching King Ahasuerus to demand redemption and pardon for her people.⁶¹⁶ Shared interests of body feminists over the years have broadened to explore body image and self-starvation outside confined disciplines generating critical dialogues on the conception of the feminine body as a cultural and political model.⁶¹⁷ Bordo regarded the feminine body as the slender body, “it is what we eat, how we dress, the daily ritual through which we attend to the body is a medium of culture”.⁶¹⁸ Empirical researchers rely on outcomes based on case studies involving young women and female children, thus allowing access at first hand to feminists to pursue theories that link the role of the

⁶¹³ Hilde Brunch, *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within* (New York Basic Books 1973) p. 22.

⁶¹⁴ Bordo, *op. cit.*, p.185.

⁶¹⁵ Esther 4:15-16, available at Bible Gateway <https://www.biblegateway.com/passage/?search=Esther%204:15-16> [accessed 10th August 2018].

⁶¹⁶ *Ibid.*

⁶¹⁷ Susan Bordo, ‘Reading the Slender Body’ in Mary Jacobus, Evelyn Fox Keller and Sally Shuttlewood (eds) *Body/Politics: Women and the Discourses of Science* (New York, Routledge 1990) pp. 83-84

⁶¹⁸ Alison M. Jaggar, and Susan Bordo, *Gender/Body/Knowledge: Feminist Reconstruction of Being and Knowing* (New Jersey, Rutgers University Press 1989) p.13.

female gender and the relationship in triggering eating disorders.⁶¹⁹ The acceptance of the thin body in this millennium is a significant contrast and departure from the Victorian era trend, which embraced curvy women. The typical Victorian female was ostentatiously unapologetic of the aesthetical body ideals they embraced. Redefining the body anatomy through self-motivation and control became a symbolic self-accomplishment. It becomes gradually apparent that the body cannot be controlled and directed in ways unconsented to by the host. The increasing number of individuals who adapt to this slender, thin and willowy aesthetics stimulates a broadened understanding and interpretation through in-depth analysis.⁶²⁰ A study at the Cornell Medical College, New York, on eating disturbance in Eastern and Western societies showed a cultural pattern of food starvation as a tool for “negotiating the transition, disconnection, and oppression that they uniformly endure.”⁶²¹ Katzman and Lee share the perspective that sole focus on body image and starvation will only bypass the superior acknowledgement surrounding the conceptualised structure of the anorexic body.⁶²² There is no true portrait representative of the meaning-centred anorexic body experience. To secure an ideal portrait in understanding self-starvation will identify a confined intersection between extended frames in disciplines amongst other factors, which recognises a person’s consistent attempt to defend and affirm personal control.⁶²³ A broader individualised intersection of their values and immediate choices are conceptually analysed within societal contexts. These cross sections of multifactorial experiences or occurrences vary from isolated food restriction, distinctive weight calculation, and desperation to

⁶¹⁹ Rebecca Coleman, ‘The Becoming of Bodies: Girls, Media Effects, and Body Image’ (2008) 8(2) *Journal of Feminist Studies* pp. 164–165.

⁶²⁰ Bordo, *op cit.* 206.

⁶²¹ Katzman and Lee, ‘*op. cit.*’, p. 385.

⁶²² *Ibid.* 386.

⁶²³ *Ibid.*

stay within a controlled scale size.⁶²⁴ The meaning-centred ideals transcend cultural metaphors directly manifested through self-starvation. These experiences reflect the free will, values and choices of the individual in restraining the body without undue influence or coercion. The quest for body perfection becomes symbolic with being in control. It is not a mere strategic uncontrolled expression reoccurring intermittently. Appropriate representations will require believing in the attitude of worth and integrity a person accepts and in many ways the body is a temple, a place of self-worship and service. Voluntary starvation enables conscious gratification and satisfaction in the feeling of hunger, an achievement equated to making a critical statement reinforcing the underlying connotation to food refusal. The resistance of the normalised body weight, therefore, becomes a mantle of self-conservancy and protection. In that sense, there is an overwhelming empowerment in having that type of control and expressing autonomy with no inhibitions.⁶²⁵

Writers such as Susan Bordo⁶²⁶ and MacSween⁶²⁷ both referenced the ‘anorexic body’ as a cohesive concept, a strategic expression of a reoccurring will to resist normalisation. As prior stated, there is a more in-depth significance and connotation to the ‘*anorexic body*’ than just the generic reference to a low body weight or BMI. Anti-normalisation and Western liberation advocates engaged the anorexic body not just because of an anomaly in the brain but also as an independent non-conformist cultural force. The meaning-centred anorexic body is symbolic in ways that transcends bodily perfection, and withholding food serves as a means of controlling

⁶²⁴ Hans-Christoph. Steinhausen, ‘The Outcome of Anorexia Nervosa in the 20th Century’ (2002) 159(8) American Journal of Psychiatry p.1284.

⁶²⁵ Hilde Bruch, *The Golden Cage: The Enigma of Anorexia Nervosa* (Cambridge, Harvard University Press 2001) p. 3.

⁶²⁶ Bordo, *op. cit.*

⁶²⁷ MacSween, *op. cit.*

and exercising authority, moral, or otherwise on the way her body shapes, forms, and develops in today's society. The symbolism of the values and pattern of behaviours exhibited by the anorexic body is often lost or downgraded by psychiatrists, clinicians and mental health professionals. It is practical to recognise that basic care and treatment of anorexic nervosa in general is problematic on the surface level and a very complex issue in theory regardless of the variations they exist. A functional structure that places the rights and freedom of the anorexic body at the centre of its decision-making is unexplored in regards to the complications and illogicality associated with involuntary treatments necessitates better protection and safeguards of their rights. The focus is on the impact of autonomous actions and how to effectively interpret legal concepts within meaning in the way that brings resolution to the way law and medicine respond to the individual diagnosed with anorexia.⁶²⁸ Keywood therefore notes that reconstructing anorexia will first involve dissecting the rather uneasy engagement or relationship between the mode of application and interpretation of the legal standpoint in medical or psychiatric conditions.⁶²⁹ Attention is therefore drawn to the "somewhat crude, biomedical explanation of the condition" with no consideration to the complex nature of the "condition and the range of disagreements over its appropriate treatment and other issues of such as mental incapacity and "endorsement of legal compulsion by means of involuntary medical treatment and detention".⁶³⁰ Justifiably before autonomous and right-based perspective to anorexia can be established, there is need to destruct the legal landscapes surrounding the interaction of law and medicine.⁶³¹ The projected rights-based approach will present greater freedom and autonomy for individuals to make critical treatment decisions

⁶²⁸ Kristy Keywood, 'Rethinking the Anorexic Body: How English Law and Psychiatry Think', (2003) 26 (6) International Journal of Law and Psychiatry pp. 600–601.

⁶²⁹ *Ibid.*

⁶³⁰ *Ibid.*

⁶³¹ *Ibid.*

concerning their bodies. It is, therefore, not extraordinary for one to advocate for a consideration and balance that respects choices, and upholds individual rights to autonomy. The challenge here is not to obliquely create an analogy of the meaning-centred anorexic body as an overzealous, rebellious being in a frantic quest for self-rule. The conception of the meaning-centred anorexic body is very personal and private to the individual. It is, by all means, a personal statement to self against interference and subjectivity. Their individualities are evident particularly in the way they function efficiently in contrast to the bulk of other mentally ill patients. The meaning-centred anorexic body is competent, can lead productive lives and most significantly, voluntarily and consciously consents to self-starvation with absolute determination to stay alive. These enumerated meaning-centred characteristics are adversative to the core features and functionality of mental disorder. Critical consideration should be given reasoning behind the development of the anorexic body with the aim of attaining a better perspective. Accordingly, uncovering the cause behind a conception plays a very significant part in understanding the dynamics of this enigmatic disorder. Such deliberation might seem mundane at first, but prior activities in the field reveal an outcome that might provide answers and clarity to legitimate questions without conforming to the obvious societal or psychiatric modality. Section 1.3 therefore draws attention to an in-depth understanding of the conceptual construction of the meaning-centred anorexic body through further analysis of contemporary themes linked to culture, media and feminism.

4.1.1 Constructing the Meaning-Centred Anorexic Body Ideal

The reoccurring obsession of the contemporary western society focuses on the ideals and metamorphosis of the physical human body. Presumably, the way people eat

(feeding pattern), semi-eat, or just succumb to various forms of starvation or food deprivation has become one of the uppermost interests of today's society. Emphases are towards the changes the human body undergoes over time, from weight gain to weight loss, overweight to thinness and vice versa. The National Health Service (NHS) explained that anorexia nervosa is not triggered by a particular cause, rather it is because of a complex mixture of psychological, environmental and biological factors.⁶³² Many clinicians working in the field agree with this assertion. However, numerous sources have provided multiple dimensions behind the core construction of the anorexic body with predominant texts alluding to media and cultural influences. Establishing contextual influences in the development of the anorexic body unmasks the systematic and organised process from which the body voluntarily migrates from the natural state to a concept. The implication is that only a voluntary and conscious body can be influenced to adopt a subjective construction of the body preferred. One will be reluctant to accept that individuals who understand, examine, engage and internalise thin body ideals are doing so involuntarily. The process of planning, studying and adapting will require a certain amount of voluntary action, skill and capability.

The complexity of the anorexic body makes it problematic and complicated to paint a universal picture.⁶³³ It is nevertheless apparent that the changing patterns, shapes, and physicality of people are at the centre of social scrutiny, criticism, and intense media

⁶³² NHS, Anorexia Nervosa – Causes Available at <http://www.nhs.uk/Conditions/Anorexia-nervosa/Pages/Causes.aspx> [accessed 1st January 2019].

⁶³³ H. Freeman, 'What is the Link Between the Media and Eating Disorders' The Guardian, 2nd August 2011 available at <https://www.theguardian.com/commentisfree/2011/aug/02/link-media-and-eating-disorders> [accessed 5th Oct. 2018].

glare.⁶³⁴ Bruch's theory expresses that the anorexic woman is influenced by the widespread pressure and scrutiny imposed on them to stay thin.⁶³⁵ The technological advancement in this millennial age has created powerful media platforms utilised as tools to market extreme fitness cultures. Goodyear rightly notes that "this is truly the age of social media".⁶³⁶ A handful of studies have shown that the combined impact of social media force (Twitter, Instagram, Facebook) has a significant implication on the self-image of the body. According to Perloff:

"Social media are filled with pictures of an individual, her online friends, and multitudes of thin-idealised images that an adolescent girl or young woman may have located and pinned to a page. Social networking sites are available for viewing, content-creating and editing 24/7, on mobile devices, anywhere, anytime, allowing for exponentially more opportunities for social comparison and dysfunctional surveillance of pictures of disliked body parts than were available with the conventional mass media."⁶³⁷

⁶³⁴ Michael P. Levine and Sarah K. Murnen, 'Everybody Knows that Mass Media Are/Are Not [pick one] A Cause of Eating Disorders: A Critical Review of Evidence for a Causal Link Between Media, Negative Body Image, and Disordered Eating in Females' (2009) 28(1) *Journal of Social and Clinical Psychology*.

⁶³⁵ Bruch, *op. cit.*, pp. 98–69.

⁶³⁶ S. Goodyear, "The Power of Social Media" (2004) available at http://www.huffingtonpost.com/samantha-goodyear/the-power-of-social-media_3_b_5161138.html (accessed 5th December 2018).

⁶³⁷ R. M. Perloff, 'Social Media Effects on Young Women's Body Image Concerns: Theoretical Perspectives and an Agenda for Research' (2014) available at <https://is.muni.cz/el/1423/podzim2014/PSY221P121/um/Perloff2014.SocialMediaEffectsBodyImage.BID.pdf> [accessed 8th October 2018].

Most recently, the ‘*fit fam*’ trend across social media platforms encouraged self-imposed ‘obsessive exercise and diet habits’.⁶³⁸ This cult movement embraces the principles of ‘*fat freedom*’ supporting fat controlled regimes as a long-term lifestyle choice.⁶³⁹ The link between the body, media influence, and eating disorders has therefore taken centre stage in subjective and fiery debates in the fields of psychology, medicine, and social-cultural studies. In most scenarios, criticisms target the widespread media portrayal of what is acceptable or normal. The skeletal being becomes representative of the ideal body image as spread across magazines, televisions, and billboards.⁶⁴⁰ Suggestions for social comparison research indicate that sustainability of what the media presents to consumers offers no viability for optional downward comparison. The obvious thing is to compare oneself against unrealistic body shapes.⁶⁴¹ The intensely and compelling anti-normalised body initiates the first response to societal and media standards. With every depiction of what perfection represents, there is a draw to undertake extreme forms of food restriction and avoiding further calorific intake.⁶⁴² Achieving these body image goals would involve a voluntary action of control manifested through a lifetime of dieting and embarking on extreme weight loss regimes and food deprivation.⁶⁴³

⁶³⁸ Kayla Inglema, ‘#Fitfam: 11 Reasons Why the Fitness Culture on Social Media Needs to be Stopped’ available at <http://elitedaily.com/life/culture/reasons-why-the-fitness-culture-on-social-media-needs-to-be-stopped/> [accessed 10th December 2018].

⁶³⁹ Ron J. Eaker, *Healthy Habits for a Fit Family* (Minnesota, Revell Books 2007) p.144.

⁶⁴⁰ S. Grabe, L. M. Ward, and J. S. Hyde, ‘The Role of the Media in Body Image Concerns Among Women: A Meta-Analysis of Experimental and Correlational Studies’ (2008) 134(3) *Psychological Bulletin* pp. 460–462.

⁶⁴¹ S. Knobloch-Westerwick and J. P. Romero, ‘Body Ideals in the Media: Perceived Attainability and Social Comparison Choices’ (2011) 14(1) *Journal of Media Psychology* pp. 27–48.

⁶⁴² C. Pawlowski, and L. Deangelo, ‘Anorexia Nervosa’ Magill’s Medical Guide (2016) available at <http://eds.b.ebscohost.com.ezproxy.glos.ac.uk/eds/detail/detail?sid=79faf40a-7ef5-4879-9300-9d3b3cb8065d%40sessionmgr102&vid=13&hid=113&bdata=JkF1dGhUeXBIPWlwLHN0aWlmc2l0ZTl1ZHMtbGl2ZSZZY29wZT1zaXRl#AN=86193892&db=ers> [accessed 5th August 2019].

⁶⁴³ NHS on Anorexia, Real Stories, Causes, Getting Help, Diagnosis, Treatment, Complications, illustrated with a video by Professor Janet Treasure, Professor of Psychiatry at Kings College London and a psychiatrist and consultant at the Eating Disorder Unit, South London and Maudsley available at <http://www.nhs.uk/conditions/Anorexia-nervosa>, [accessed 4th January 2019].

Unsurprisingly, there is no data on the exact moment the patient-centred anorexic body is triggered. The lack of traceable period supports the narrative that mental disorders are involuntary and can occur without any rational and logical cause. This notion aligns with the way treatment professionals approach treatment and care mechanically without due consideration of the narrative behind the anorexic body. It is logical that certain environmental and social factors can command a degree of influence on how an individual engages and responds to what they believe and consider ideal. The medical model does not engage or explore this line of thought. Documented research outcomes primarily point to societal pressure and the influence of mass media as the significant stimulant to the development of anorexia. For instance, Brunch notes that the primary cause of anorexia in women is wide spread pressure and scrutiny imposed on them to stay thin.⁶⁴⁴ There is also the contributed factor of aspiring to fit into the societal standard of beauty and perfection, which serves as a powerful propeller for the anorexic body to explore a particular voluntary pattern. To such individuals, achieving the self-serving body image would involve a period of dieting and extreme weight loss regimes and food deprivation.⁶⁴⁵ Treasure also attributed the cultural phenomenon of size zero, which has become an acceptable trend in modern society, as a powerful trigger among young women especially and adults who aspire to emulate the media and societal standard of beauty.⁶⁴⁶ Despite widespread social and environmental influences, it is also a matter of choice to pursue the ideal to fit into the size zero profile. Since food deprivation is a voluntary action in the intensive pursuit of thinness, the period for conceptualisation and implementation

⁶⁴⁴ Brunch, *op. cit.*

⁶⁴⁵ NHS on Anorexia, Real Stories, Causes, Getting Help, Diagnosis, Treatment, Complications, illustrated with a video by Professor Janet Treasure, Professor of Psychiatry at Kings College London and a psychiatrist and consultant at the Eating Disorder Unit, South London and Maudsley. Available at <http://www.nhs.uk/conditions/Anorexia-nervosa>, [accessed 1st Apr. 2019].

⁶⁴⁶ *Ibid.*

is traceable and therefore can be documented. What is significant in the present to Treasure and similar writers is the overwhelming implication placed on societal pressure and scrutiny of the human body.⁶⁴⁷ In the face of competing claims surrounding the same issue, for the anorexic body to conform to this societal expectation and existence would require a voluntary action and determination to self-starve or restrict food intake.⁶⁴⁸

Until most recently, making connections between altered image advertisements, for instance, and the development of eating disorder are usually secluded from public discourse and restricted to the private domains.⁶⁴⁹ Making the connection between the cause and reasoning will demystify the paranormal notions associated with mental disorders. Regardless, more studies show that the continuous media projection of unattainable body perfection aesthetics while consciously concealing the use of digital alterations, such as Photoshop and retouching, lead to negative perception of one's body and amplifies the need to create a perfect body. Hesse-Biber suggests that women are more susceptible to learning from media outlets that promote a less than ideal body weight, rather than from outlets that promote a positive body image.⁶⁵⁰ Extreme dieting and exercise to achieve the idolised thin body projected by media becomes synonymous with identity and body image.⁶⁵¹ It is safe to assume in that scenario that the make-believe world created by the media is misrepresented as real,

⁶⁴⁷ Brunch, *op. cit.*

⁶⁴⁸ Rogers and Pilgrim, *op. cit.*, p. 2.

⁶⁴⁹ Galya Hildesheimer, and Hemda Gur-Arie, 'Just Modelling? The Modeling Industry, Eating Disorders, the Law' 8(2) International Journal of Feminist Approaches to Bioethics, pp.103–105.

⁶⁵⁰ Sharlene N. Hesse-Biber, Patricia G. Leavy, Courtney E. Quinn, and Julia Zoino, 'The Mass Marketing of Disordered Eating and Eating Disorders: The Social Psychology of Women, Thinness and Culture' (2006) 29 Women's Studies International Forum p. 220.

⁶⁵¹ Yuko Yamamiya, Thomas. F. Cash, Susan E. Melnyk, Heidi D. Posavac, and Steven S. Posavac, 'Women's Exposure to Thin-and Beautiful Media Images: Body Image Effects of Media-Ideal Internalization and Impact-Reduction Interventions' (2005) 2(1) Elsevier Body Image p.75.

thereby raising negative body image.⁶⁵² According to Bordo, eating disorders were unheard of in countries such as China, South Korea, and Japan before Western influence. Fiji Island also had no record of eating disorder prior to accessing television in 1995.⁶⁵³ Through the continuous projection of unattainable body perfection aesthetics, there is also a consciousness in concealing the use of digital alterations such as Photoshop and retouching. The unattainability of the perfect body, combined with the negative perception of one's body, amplifies body consciousness.⁶⁵⁴ A report published in experimental study amongst 123 female college youths overwhelmingly indicated that media exposure had a dominant effect on body image. Media promotion of 'unrealistic thin ideals are associated with detrimental effects on women and girls' moods, body image, and eating pattern'.⁶⁵⁵ Most surprising, Alexandra Shulman, former editor in chief of the UK's most iconic fashion bible, *British Vogue*, disagree. According to ITV lunchtime news, Shulman stated that it was unfair to allude to the media culture in promoting size zero models as instrumental to the development of eating disorders or body image issues. For her, internalising those ideals depicted in the magazine was a result of other underlying issues outside the influence of mass media. Disagreeing with Shulman, Grabe insists that there is a demonstrated link between internalising these projected standards popularised by the media with both physical and mental illness issues relating to developing various forms of eating disorder.⁶⁵⁶ Hildesheimer and Gur-Arie accuse the modelling industry as the overriding factor in developing various forms of eating

⁶⁵² Jolanda Veldhuis, Elly A. Konjin, and Jacob C. Seidell, 'Counteracting Media's Thin-Body Ideal for Adolescent Girls: Informing Is more Effective than Warning' (2014) 17(2) *Journal of Media Psychology* pp. 154.

⁶⁵³ Bordo, *op. cit.*, p. xv-xvi.

⁶⁵⁴ Yamamiya, *et al*, *op. cit.*

⁶⁵⁵ Marika Tiggemann, 'The Status of Media Effects on Body Image Research: Commentary on Articles in the Themed Issue on Body Image and Media' (2014) 17(2) *Journal of Media Psychology* p.127.

⁶⁵⁶ Grabe, *op. cit.*

disorder through the constant media publicity of photo-shopped images and false advertising of ultra-thin models.⁶⁵⁷ It therefore, seems that largely, the anorexic body is susceptible to the manifestation of the pressures of modern life and society.⁶⁵⁸

According to Lopez-Guimera, the “mass media are an extremely important source, if not the principal source”⁶⁵⁹ of thin body internalisation. Evidence shows that young girls familiarised with magazines that promote appearance-based beauty ideals show the ultimate body discontent.⁶⁶⁰ In many instances, evidence demonstrates that the exposure level to internalising the thin body ideal can and has triggered disordered eating, body dissatisfaction, and displeasure.⁶⁶¹ Similarly, there is also a link between idolisation and attraction to thin media personalities and eating disorder.⁶⁶² Actually, the postmodern body is increasingly nurtured on fantasies of rearranging, transforming, and correcting limitless improvement and change, defying the very historical antecedents. Take, for instance, the historic switch from the curvy woman to the thin woman idolisation in Nigeria, a country notorious for the appreciation of a ‘well rounded’, curvy woman. The author has been told that she was too skinny to make an honest woman for an African man. Then the 2003 media frenzy when the thinnest woman ever to grace the world stage took home the most coveted Miss World title.⁶⁶³ Agbani Derego, a Nigerian, was the opposite of the body norm celebrated by Africans. Following Agbani’s win, Nigeria’s Oluchi became the biggest

⁶⁵⁷ Hildesheimer and Gur-Arie, *op. cit.*

⁶⁵⁸ Anne Erichsen, *Anorexia Nervosa: The Broken Circle* (Norfolk, Thetford Press 1985) p. 12.

⁶⁵⁹ Gemma Lopez-Guimera, Michael P. Levine, David Sanchez-Carracedo, and Jordi Fauquet, ‘Influence of Media on Body Image and Eating Disordered Attitudes and Behaviors in Females: A Review of Effects and Processes’ (2010) 13(4) *Journal of Media Psychology* pp. 387.

⁶⁶⁰ *Ibid.*

⁶⁶¹ Nicole Hawkins, Philip S. Richards, Mac H. Granley and David M. Stein, ‘The Impact of Exposure to the Thin-Ideal Media Image on Women’ (2004) 12(1) *Journal of Treatment & Prevention* pp. 35-36.

⁶⁶² Kristen Harrison, ‘Does Interpersonal Attraction to Thin Media Personalities Promote Eating Disorders’, (1997) 41(4) *Journal of Broadcasting and Electronic Media* pp. 478–479.

⁶⁶³ BBC, Miss World Win Boosts Nigeria available from <http://news.bbc.co.uk/1/hi/world/africa/1661191.stm> [accessed 16th October 2018].

model export from Africa to grace the world stage after winning the M-net Face of Africa competition.⁶⁶⁴ Like Agbani, Oluchi, a size zero, represented the thin body ideal. The new wave of media frenzy ushered in the new standard of beauty. The ‘Lepa’⁶⁶⁵ thin woman status took centre stage,⁶⁶⁶ dethroning the old ‘oroobo’⁶⁶⁷ standard of beauty. Although Nigerians previously opposed to the post-modern thin woman accepted the modern ascetic body ideal, it became apparent that the new culture has also furthered social division. The consequences were a wave of genetically endowed women struggling to fit into media and societal interpretation of body perfection. To construct the thin body would involve a conscious system of extreme dieting, excessive exercise, and starvation, which is an established outcome of the thin ideal internalisation.⁶⁶⁸

Another dimension exposes that the media parade of skinny models will continuously have a tremendous impact on the body image of the consumer.⁶⁶⁹ It is, therefore, impossible to argue with the reasoning that suggests the contrary as portrayed by *British Vogue* Editor, Shulman. Murray suggests the importance of treatment programs for managing and treating eating disorders to confront and tackle head-on the media presentation of body image and ideals.⁶⁷⁰ The attitudes of the media prognostications of the thin body ideals are so compelling and forceful that there is a

⁶⁶⁴ Oluchi Orlandi. available at <http://antmafrica.com/oluchi/> [accessed 3rd August 2018].

⁶⁶⁵ ‘Lepa’ is a popular Yoruba slang for the thin woman.

⁶⁶⁶ Bordo, *op. cit.*, p.xv.

⁶⁶⁷ ‘Orobo’ is a Yoruba slang for curvy women.

⁶⁶⁸ Kevin J. Thompson and Eric Stice, ‘Thin-Ideal Internalization: Mounting Evidence for a New Risk Factor for Body-Image Disturbance and Eating Pathology’, (2001) available at <http://jkthompson.myweb.usf.edu/articles/Thin-Ideal%20Internalization.pdf> [accessed 10th Sep. 2018] pp. 181–182.

⁶⁶⁹ Amanda Holmstrom, ‘The Effects of the Media on Body Image: Meta-Analysis’ (2004) 48(2) *Journal of Broadcasting & Electronic Media* p. 198.

⁶⁷⁰ Sara H. Murray, Stephen W. Touyz, and Peter J. V. Beumont, ‘Awareness and Perceived Influence of Body Ideals in the Media: A Comparison of Eating Disorder Patients and the General Community’ (1996) 4(1) *Journal of Treatment and Prevention* pp.33–46.

clear, definitive message and dissemination of information.⁶⁷¹ The nature of anorexia exposes the depth of the individual's positive or negative feelings, convictions, and behavioural responses.⁶⁷² For an anorexic body, there is a consensus of equating self-starvation (physicality and appearance of thinness) with identity, self-worth, and body integrity. The concept of the '*anorexic body*' is an individualistic self-statement against interference and body subjectivity and a direct reaction to a person's personal or social movement.⁶⁷³ Individualised actions would, therefore, align with resistance to the oppression of the normalised body image in the quest to self-determine.⁶⁷⁴ The ascetic body therefore transcends mere cultural metaphors and manifests through self-starvation and extreme dieting.⁶⁷⁵ The challenge here is to avoid creating an analogy of the anorexic body as riveting in this quest to self-rule at all cost. Although, this might be the only choice left for the meaning-centred anorexia bodies subjected to involuntary treatments.

Analysing the anorexic body in the context of protection, dignity, bodily integrity, rights, and freedoms is complicated and challenging. Ordinarily, everyone should possess the right to take control of the choices regarding their body, wellbeing, and means of reproductions 'without fear, coercion, violence and discrimination'.⁶⁷⁶ Ideally, incorporating certain aspects of that, a person's values and choices are fundamental to rights protection and should not be relegated to the background. MacSween asserts that at the core of self-rule is a dimension within the social context

⁶⁷¹ Anne E. Becker and Paul Hamburg, 'Culture, the Media, and Eating Disorders', (1996) 4(3) *Harvard Review of Psychiatry* pp.163-164.

⁶⁷² Grabe, *op. cit.*, p. 462.

⁶⁷³ MacSween, *op. cit.*, p. 4.

⁶⁷⁴ Bordo, *op. cit.*

⁶⁷⁵ *Ibid.*

⁶⁷⁶ Amnesty International USA. 'My Body, My Right' available at <http://www.amnestyusa.org/our-work/campaigns/my-body-my-rights> [accessed 10th February 2019].

in which an anorexic body can exhibit meaningful existential strategy resurrecting a new wave of female aspiration to patriarchal individualism.⁶⁷⁷ For Orbach, research has shown that food refusal is a symbolic attempt to self-assert. She explains that a woman's body is the place where she objects or protests a wrong.⁶⁷⁸ In a *Local Authority v E*, E, had a relative awareness of exceptionally happy childhood, with parents and siblings who loved and supported her. At the tender ages of eleven and fourteen, E experienced the worst type of sexual abuse.⁶⁷⁹ Victims of sexual assault often establish that there is the element of violation not just of the body but the mind, soul and essence of being. Distinctive traits also reveal that the variable patterns adopted by the perpetrators effectively lack consent, deprivation of freedom and disregard for the individual's choice. The sexual assault triggered a sense of deprived control of her body occasioning self-starvation and food refusal as a mechanism to reclaim the body. E's body invariably becomes the ground where the battle for control is fought and maintained.

The rise of the liberal feminist movement in the 1970s played a dominant role in advancing female identification with the body. The move engineered the notion that the critical analysis and understanding of the intricacies of gender will reveal repressed aspects of culture and history.⁶⁸⁰ Before this, issues associated with the body were downplayed, 'considered too vulgar trivial or risqué to merit serious scholarly attention'.⁶⁸¹ In every sense, anorexia nervosa reflects the female

⁶⁷⁷ MacSween, *op. cit.*

⁶⁷⁸ Susie Orbach, *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age* (Abington, Routledge 2018). p. xvii.

⁶⁷⁹ *A Local Authority v E* [2012] EWHC 1639 (COP).

⁶⁸⁰ Susan Bordo, *Unbearable Weight: Feminism, Western Culture, and the Body* (London, University of California Press 2003) p. 216.

⁶⁸¹ Londa Schiebinger, *Feminism and the Body* (Oxford, Oxford University Press 2000) pp. 1–11.

experiences in a gender conformist society dominated by the physicality of the institutions that influence it rather than mentally driven. Female bodies show more obvious traits to influence and control. There is a constant awareness on every corner mainly targeted at female consumers. Historically, there have been gender-specific oppressions in all facets of life. For decades, women have fought hard to overcome inequality, sexism, and gender-based repression. Women empowerment movement initiatives often focus on furthering the female agenda regarding empowerment and social acceptance. The need to be independent and autonomous in managing their affairs has always been an essential part of that movement. Despite the common emphasis on conformity to assigned roles and functions in the home or society, the broader modern woman is emerging from obscurity to assert her independence in ways outside the traditionally accepted framework. For instance, the memoirs of African women account for cultural relegation to the backgrounds as cooks, home keepers, and child bearers. Their physical body, reproductive organs, and mental health are dominated by the male influence discarding their values, wishes, and aspirations. In that society, tradition demands the female fulfil and adhere to those roles for the continuous protection of the cultures of their forefathers, which ultimately furthers the 'supremacy of men'.⁶⁸² The female body parts become a mutually exclusive mechanism for labour—the hands to pound cocoyam, the breasts to feed the child, the womb to carry the foetus, and the vagina as a device of birth and pleasure. These roles and functions are created and imposed by existence as the female gender. Overpowered, they retreat in silence and intimidation. Foucault however focused on the positive nature of power, disagreeing with the notion that men are capable of holding power over women. To Foucault, people can only exercise

⁶⁸² Bene E. Madunagu, 'The Nigerian Feminist Movement: Lessons from *Women in Nigeria*, WIN' (2008) 35(110) *Review of African Political Economy* p. 666.

a degree of power and expressions of male oppression should only be recognised in a wider context rather than tailored to a specific group. Foucault's view fails to offer answers to the oppressive elements in the experiences of women.⁶⁸³ According to Ramazanoglu:

Knowledge of domestic violence cannot then be produced without taking account of women's experience, but such knowledge is not confined to that experience, it is simultaneously always embodied and conceptualized...feminists need to go beyond Foucault's analysis of power, by hanging on the radical feminism's sense of moral outrage while modifying this with the recognition of the diversity of women's condition in life.⁶⁸⁴

The effects and influence of male dominance of the female body has been a constant feature on the templates of gender-based issues. Many feminists are beginning to expand on the connection between the female negative experiences and understanding power in relation to men and vice versa. Feminist constructions will draw on the overwhelming presence of male dominance and sexual oppression of women as tied in with their body experiences and attitudes. It symbolises a revolution against the customary norm whereby men in the traditional society shape women's perception of their body. Foucault's theories have not often thrived within the radical feminist movements. Nevertheless, it possesses key beneficial components in incorporating

⁶⁸³ Allison C. Tschannen, 'An Argument of Incentivizing Voluntary Regulation of the Fashion and Modeling Industries' (2014) 6(2) Washington University Jurisprudence Review p. 423.

⁶⁸⁴ Caroline Ramazanoglu, *Up Against Foucault: Explorations of Some Tensions between Foucault and Feminism* (Abington, Routledge 1993) p. 17.

gender, sex, and bodies as a social construction. The body has exceeded pure biological entity and every attribute it undergoes as a medium of social control sums up its experience. These accounts of women's experience can be dysfunctional or functional, negative-positive but also unique to each person. Engaging in a social construction, highlighting the struggle around women bodies and sexuality devoid of Foucault's masculinity driven agenda is a discourse not readily dismissed. Value is placed on unseating a cultural phenomenon as vehicle of social change and the ultimate response to the predicaments of self-rule.⁶⁸⁵ Establishing this connection is essential to 'preserving some understanding of the women's agency and possibilities of empowerment.'⁶⁸⁶

Fallon insists that the emaciated thin body is a form of escapism from the typical portrayal of a woman as a sexual object and their quest to return to their child-like state.⁶⁸⁷ Crisp also considers this child-like body reversion as a form of expression of freedom and control on the body.⁶⁸⁸ Accordingly, feminine individuality can only be attained through the resistance of weight gain by embracing the freedom of regressing back to a child-like development state to avoid the overwhelming prospects of embracing sexuality.⁶⁸⁹ Avoiding engaging in sexuality or sexual behaviours can then be valued as an appropriate response against male dominance of the female body and the way they view the body as an object for exploration and, in some cases, exploitation. On this account, desexualising the body in a way that prevents the

⁶⁸⁵ Angela McRobbie, 'Post-Feminism and Popular Culture' (2004) 4(3) *Journal of Feminist Media Studies* pp. 255–256.

⁶⁸⁶ Ramazanoglu, *op. cit.*, p. 12.

⁶⁸⁷ Fallon, Patricia., Katzman, Melanie A., and Wooley, Susan C., (eds.) *Feminist Perspectives on Eating Disorders* (New York: Guilford Press 1974).pp. ix-x.

⁶⁸⁸ Crisp, *op. cit.* p. 204.

⁶⁸⁹ H. Malson and M. Burns, *Critical Feminist Approaches to Eating Dis/Orders* (eds.) (New York, Routledge 2009). p.176.

further development of the rather attractive parts of the body adds a blanket of protection and control. Suggestions about the link between anorexia nervosa and the response to the crises about autonomy and independence in women have become dominant. This crisis can occur at any stage of a person's celebration of self-determination⁶⁹⁰ struggle for independence and assertion of the right to make their own decisions. For an anorexic woman, her body is the ground where her protest occurs and where she battles against control and domination.⁶⁹¹ There is always a paradigm shift from just a desire to stay thin to also a desire to be in control and exert influence on her body. It is the thought of losing that right to self-rule or independence that creates the need to maintain a low body weight or BMI.

For MacSween,⁶⁹² delegating power to medical practitioners over women with anorexia is counter-productive and denotes a form of feminist oppression.⁶⁹³ One must also note that the clinical pressure placed on an anorexic woman to put on weight and, in essence, 'recover', offers little or no relief for the anorexic and the medical practitioner. *L v NHS*⁶⁹⁴ demonstrated that, despite evidence that it was impossible to extend L's life by involuntary artificial nutrition.⁶⁹⁵ Treatment professionals continued to subject L to the best medical care by experts in the field. L's weight continued to decrease drastically. There was no surprise when treatment professionals tentatively arrived at the opinion that involuntarily treating L by force-feeding would have little or no impact on her recovery or life preservation.⁶⁹⁶ In most cases of anorexia, enforcing further compulsory treatment would only reinforce her

⁶⁹⁰ Keywood, *op. cit.*, p. 604.

⁶⁹¹ Orbach, *op. cit.*, p. xvii.

⁶⁹² MacSween, *op. cit.* pp.14–15.

⁶⁹³ *Op. cit.* p.18.

⁶⁹⁴ *Ibid.*

⁶⁹⁵ *NHS Trust, v L, op.cit.*, para, 7

⁶⁹⁶ *NHS Trust v L, op.cit.*, paras 1–3

disability and worsen her eating disorder.⁶⁹⁷ Then again, the clinical justification for involuntary treatment of anorexia nervosa fails to consider the aftereffect of their action including the positive and negative experiences. Contrary to psychiatric and medical assertions, immense amounts of third party pressure and scrutiny do not favour the individual and are often detrimental to the long-term recovery process. For Giordano, there exists no evidence to show that involuntary hospitalisation for the treatment of the mental disorder of anorexia patients leads to long-term recovery.⁶⁹⁸ Clinicians involved in treating and managing the anorexic body often struggle to accept the above, although overwhelming treatment outcomes reveal relapse immediately after release from unconsented treatment.

Every crystallised layer of anorexia nervosa provokes a debate at some level. Contextualising post-modern theories provide a better understanding of the many significant layers that contribute to the uniqueness of the anorexic body. The woman's paramount interest is in taking control of her body as a way of self-expression, especially when she feels vulnerable and defenceless.⁶⁹⁹ To stay in control means resorting to strict dieting, calorie counting, excessive exercising, missing meals (fasting), conscious and deliberate starvation, and taking appetite suppressants and slimming pills. Feminist contribution to understanding eating disorder, in general, has somewhat challenged the standardised medical model.⁷⁰⁰ Food refusal has become an essential part in creating a new person separate from herself. A woman trying to assert her position in this world will first attempt to curb the emotional aspects of her being. The discipline accompanying food refusal is therefore an essential part of her journey

⁶⁹⁷ *NHS Trust v L*, op.cit, para 23

⁶⁹⁸ Giordano, *op. cit.*

⁶⁹⁹ Orbach, *op. cit.*, pp. 1–12.

⁷⁰⁰ Bordo, *op. cit.*, p. 63.

to draw a line between her needs and self.⁷⁰¹ Orbach therefore asserts that the daily routine of the anorexic is fundamental to fulfilling her wishes and needs and significantly includes controlling their wishes and desires by muting the existence of other bodily demands, which do cater to the fulfilment of their goals. Invariably, “demanding a super human submission to the denial provides a self-contained and reliable way of being”.⁷⁰²

Within the feminist narrative, the female anorexic body has gradually progressed to a stage of acknowledgement as more than a mere biological essentialism to be profoundly recognised as a symbolic representation of ‘the enactment of women’s struggles for independence’⁷⁰³ and female emancipation. The unflattering and incorrect portrayal of the anorexic body in academia and popular culture as unsuccessful and disingenuous solidifies the stereotypes and progresses the continuous stifling and suppression of her voice, opinions, thoughts, reasons, and motive.⁷⁰⁴ Rethinking the way we view eating disorders can spearhead an acceptance of its background within ancient moral values, which has now become an integral part of the ordinary morality in western societies. In light of this logical moral sequence, re-thinking the understanding of eating disorders, such as anorexia, will realign autonomous arguments and adjust the *prima facie* behaviour of clinicians towards anorexic patients.⁷⁰⁵ The limitations of the medical model can be micro-managed within a framework that is devoid of the body politic and tolerant of the cultural metaphors of self-determination, will, and autonomy. Joana Whiteman explains that

⁷⁰¹ Orbach, *op. cit.*, p.xvii.

⁷⁰² *Ibid.*

⁷⁰³ Stephanie H. Grey, ‘A Perfect Loathing: The Feminist Expulsion of the Eating Disorder’ (2011) 7(2) *The Journal of Kenneth Burke Society* p. 63.

⁷⁰⁴ Grey, *op. cit.*

⁷⁰⁵ Gordano, *op. cit.*, pp. 254–257.

cases, such as *Re E*,⁷⁰⁶ are a reflection of the struggle to balance safeguarding best interest through the preservation of life while also respecting individual freedom and autonomy to make decisions.⁷⁰⁷ Most anorexia nervosa case law reveal strong indication that when courts are faced with the complexities of anorexia, the courts are predisposed to take the side of preserving life. There would always be a struggle between respecting the liberty, ideals, and best wishes of the anorexic body, especially if those choices do not aid the clinical driven ‘recovery’ in any way. In this regard, the question of what is in the best interest of the anorexic body would always emerge. Should the best interests of the anorexic body not include their choices, consented decisions, values, morals, and expectations?

There is a process for engaging in in-depth fact finding which reflects the diverse perspective and experience of the individual whilst incorporating the community of relationships including family members and friends. Ensuring personal responsibility and transparency will eliminate the friction of forcing the person to partake in actions against their wishes, embracing their unbiased values and promoting personal autonomy. According to Matusek and Wright, an integrative, collaborative and culturally sensitive approach may include accepting the person’s decision to exist in her ideal body weight.⁷⁰⁸ Regardless of the diminishing BMI level, consideration is given to extending care and treatment within the comfort of their homes rather than being detained in a hospital against their will.⁷⁰⁹ There are also situations that may warrant inclusive negotiation to arrive at a decision on the quantity of food, which the

⁷⁰⁶ *Re E* (Medical Treatment Anorexia) *op. cit.*

⁷⁰⁷ Joanna Whiteman, ‘Limiting Autonomy? Mental Capacity to Refuse Treatment in the UK’ *The Equal Rights Review* (2012) 11(149) available at http://www.equalrightstrust.org/ertdocumentbank/err9_whiteman.pdf [accessed 17th August 2019].

⁷⁰⁸ Matusek and Wright, *op. cit.*

⁷⁰⁹ *Ibid.*

anorexic body feels comfortable to consume within a given period. Regardless of the approach involved in assessing, treating and managing the body, current trend shows that it is important that future complications are mitigated. Creating meaning-centred anorexic body preserves the individual's voluntary and autonomous actions in their best interest.

CHAPTER FIVE

Cross Cultural Dimensions in Nigeria

5.

Chapters 1, 2, 3, 4 examines the core themes in redefining anorexia nervosa as not exclusively a mental illness and by identifying individualised contemporary socio-cultural factors and values. There is therefore, multi-layered contributing factors not accounted for by solely adopting a medical or psychiatric narrative. The previous chapters examined the meaning centred anorexic body within a rational, voluntary and logical narrative freestanding of psychiatric modalities. The previous chapters therefore provide the theoretical context to the fundamental aspects of this thesis and provided the background for the empirical study in this chapter. The first part of this chapter briefly offers an overview of a cross-cultural dimension of Anorexia as a non-western bound syndrome. Across non-western patterns there is a masked history of self -starvation and extreme thinness embedded in experiences that results to individuals challenging and resisting the socio-cultural and political bodily oppression. The empirical study in this chapter will explore themes of self-determination, autonomy and bodily integrity by examining the underlying meaning of thinness as a result of self starvation in a none western culture. Nigeria has no institutionalised mental health law or practice, which further the narrative of anorexia as solely a psychiatric condition. Individuals who exist with the anorexic body spectrum (BMI – under 17) do so willingly, voluntarily and within meaning. Nigeria therefore possesses a unique system and structure, which allows unbiased empirical investigation about likely behavioural patterns and categories in analysing anorexia as a non-western bound syndrome.

5.1 Background of Study

Anorexia nervosa is a mental health condition and overtime has gained wide attention within medical circles around the world. However, regardless of its new status and the attention given to it in the developed world, this condition and other eating disorders have not attained the same status outside the western world. Similar to other developing countries, Nigeria presents a unique environment to explore the cross-cultural themes in the discourse. Clark suggests it is “reasonable to look for helpful analogies in alien culture of present.”⁷¹⁰ The narrative of anorexic nervosa and other eating disorders as a complex medical and psychiatric illness is rarely acknowledged in Nigeria hence very few medical professionals in Nigeria have carried out studies into the conditions. Hoeken, et al note that very few cases of eating disorders were found however, anorexia nervosa have not been reported in literature.⁷¹¹ These researchers examined literature on the epidemiology of eating disorders in the African continent using the DSM-IV criteria and found that none of the 1476 cases of young females that they studied showed the condition.⁷¹² The result of the study concluded that epidemiological studies of eating disorders in Africa are still in its infancy. However, Unuhu, et al observed from their research that few cases of the condition have been reported in Africa.⁷¹³ They noted that four (4) cases were reported in Nigeria and one (1) in Zimbabwe. Their result led them to suggest that anorexia nervosa may not be uncommon in Africa as previously assumed and stressed that

⁷¹⁰ Clark, *op. cit.*, p.4.

⁷¹¹ Daphne Van Hoeken, Jonathan K. Barn, and Hans W. Hoek, ‘Epidemiology of Eating Disorders in Africa’ (2016) 29(6) *Current Opinion in Psychiatry* pp. 372-377.

⁷¹² *Ibid.*

⁷¹³ F. T. Unuhu, N. W. Ebiti, G. O. Oju, and S. B. Aremu, ‘Anorexia Nervosa in a Nigerian: A Case Report’ (2016) 50 (1) *Nigerian Medical Journal* pp.23-24. available at <http://www.nigeriamedj.com/article.asp?issn=0300-1652;year=2009;volume=50;issue=1;spage=23;epage=24;aualast=Unuhu> [accessed 21st September 2019].

these calls for concern and a need to pay more attention to the condition.⁷¹⁴ Understandably, the low number of anorexics found in the African female population is not surprising and may be connected with the African conception of beauty.

It is long established that eating disorders are grounded in western cultural models of feminine beauty.⁷¹⁵ In the first instance, the standard practice of medicine regarding mental illness focuses on the way the individual presents their views about themselves and the external world.⁷¹⁶ These perceptions often differ from the standard norms as judged by a third party observer. The observer in turn makes a judgement decision on the mental state of the individual through a direct analysis of whether their values and beliefs is in conformity with the external views of the society.⁷¹⁷ The identity of the individual to the observer systematically develops from there however treatment judgment is formulated by identifying by behaviours indicative of mental illness. It is established that the complexity, experiences and strains of modern life play intricate role in the social interaction and behaviours an individual is accustomed to. The challenge is identifying receptive indicators of mental disorder, which reflects the conscious struggle for biological survival. The difficulty lies in separating bodily illness – a transition of the body wilfully – and mental illness – unconscious transition. Bodily transitions, which may or may not be accompanied by physical

⁷¹⁴ *Ibid.*

⁷¹⁵ Mitchell Weiss, 'Eating Disorders and Disordered Eating in Different Cultures' (1995). 18(3) Psychiatric Clinics in North America pp.1-23 available at <https://dash.harvard.edu/bitstream/handle/1/35642709/18-Eating%20disorders%20and%20disordered%20eating%20in%20different%20cultures.pdf?sequence=3&isAllowed=y> [accessed 10th September 2018].

⁷¹⁶ Szasz, *op. cit.*, pp.15-16.

⁷¹⁷ *Ibid.*

illness, can then be evaluated by the “structural and functional integrity of the human body”.⁷¹⁸

Non-western culture bound classifications rely on the peculiarity of conditions or lack thereof to explain disordered behaviour. For instance, the most remarkable explanation exists in environments where the standard diagnostic criteria do not apply and individuals exhibiting certain symptoms consistent with the DSM-5 classification of mental disorder are removed from the standardised coherent and comprehensive ordering of mental illness. In the absence of the standardised analysis mechanisms by the DSM, meaning can be sought within cultures reflective of the person’s values and to a larger extent, social and familial norm.⁷¹⁹ The task will be on how best to engage both the cultural, ethnic and social cultural background of the individual to extract meaning underlying their convictions and values as influenced by their choices arbitrarily or otherwise. Brody suggests an introduction of bio-cultural clinicians from the same or similar background as the individual and can engage with the reasoning behind any decision. This approach means that the clinician must work out his/her own identity within a strange culture in relation to the patient”.⁷²⁰

There is a consensus across social disciplines that the cultures and the way of lives of individuals vary across cross-cultural borders. An individual is therefore an embodiment of their immediate environment, which reflects their experience, personhood and reality. Saravan et al note “in a basic way, the self is a by-product of

⁷¹⁸ Szasz, *op. cit.*, pp.15-16.

⁷¹⁹ DSM-5, *op. cit.*, p.14.

⁷²⁰ Brody, *op. cit.*, p.9.

cultural meaning system”.⁷²¹ In defining cultures, it is imperative to contend the peculiarity to an individual, which is interconnected to moulding their perception, meaning, behaviour and characteristic.⁷²² It is therefore inappropriate to comparatively analyse an individual within different cultural settings not peculiar to their experience – outside the setting where their ideologies and meanings form.⁷²³ There are clear-cut differences across cultures, which might be impractical in the overall experience of the individual.⁷²⁴ However, there are strong indicators that social and cultural factors are important determinants in conceptualizing illness and seeking help. It is therefore imperative that accounts of personal experiences of non-western people are explored within their prevalent culture and way of life. Understandably, analysing different personal perspectives and lived experiences can provide multiple meanings that can reveal the true nature of the individual.⁷²⁵ Saravan et al therefore contend that the challenge concerns the outcome of adopting “different systems of meaning, individuals perceive the world differently, conceptualise differently and emote differently. In a basic way, the self is a by-product of a cultural meaning system”.⁷²⁶

Historically, advocacy for freedom of choice, autonomy and consent of the anorexic body has been flawed by clinical impositions of treatment options to facilitate recovery. Regardless of the invasive treatment options to facilitate recovery, there is still a record of chronic high mortality rate, low recovery, and a distinctive treatment

⁷²¹ B. Saravan, C. Manigandan, A. Macaden, G. Tharion, and S. Bhattacharji, ‘Re-examining the Psychology of Spinal Cord Injury: A Meaning Centered Approach from a Cultural Perspective’ (2001) 39 (6) Spinal Cord pp. 323 – 326.

⁷²² *Ibid.*

⁷²³ *Ibid.*

⁷²⁴ *Ibid.*

⁷²⁵ *Ibid.*

⁷²⁶ Saravanan, *op. cit.* pp. 323-234.

resistance.⁷²⁷ This stringent clinical criterion based on physical emaciation firmly and instantaneously bans a cross border of individuals within a patient-centred spectrum without providing alternative range for others to embrace the autonomy to self-determine. The patient centred approach solely favour immediate detention for the treatment and care of their mental disorder with no consideration for the choices, decisions (advanced or not) of the individual thereby stripping the individual of the liberty to self-determine in favour of immediate detention for treatment and care.

Masked history of self-starvation, food refusal and extreme thinness transcend western clinical/medical ideologies. An in-depth cross-cultural analysis engages the cultural contexts of anorexia exclusively, embedded in their experiences and within self-discipline, self-determination and assertion of bodily integrity and autonomy. Engaging the personal and underlying meaning of the anorexic body ensures that the choices, norms, values and decisions (meaning-centered) of the individual are hierarchical to the established presumptions of mental illness. It is, therefore, relevant to analyse anorexia outside western bound syndromes and within cultures where anorexia nervosa is not recognised as a mental illness and classic symptoms of anorexia (fear of weight gain, extreme thinness, self-starvation and food refusal) are symbolic to self-discipline, religious or cultural rituals. For instance, the established western beauty ideal – tall, thin and straight through hips – does not appeal to men of African heritage. An analysis of the favoured body type of African-American and Caucasian men revealed that African American men prefer and are "more accepting of larger sizes for women than Caucasian men."⁷²⁸

⁷²⁷ Tan, *et al*, *op. cit.*, pp. 267–272.

⁷²⁸ Freedman, *et al*, *op. cit.*, p.319.

Lamb concludes that “being fat is a beauty ideal for much of Africa” and the fattened woman presents a way into the love, respect and heart of the man.⁷²⁹ The ideal West African woman is well endowed; the fuller and curvier woman is considered the apple of the man's eye and their bodies’ possessions or assets of their husbands.⁷³⁰ According to Ghosh, “most women of Ghana shun the emaciated figures of fashion models and believe that being “full figured” denotes not only attractiveness, but as good health and prosperity”.⁷³¹ In Nigeria, the *Orobo* woman is the standard of beauty, fat, fleshy, big, curvy and voluptuous. Cultural practices in Calabar (Southern Nigeria) mandates girls as young as six years old to be “fattened up” before they get married.⁷³² Long-standing tradition of the Efik tribe guarantees that a woman is sent to the fattening room where she is isolated from her village, removed from any physical activity and made to eat as much as she can against her will.⁷³³ The process is also associated with ensuring her hips are broadened for reproduction. The female body therefore implies desirability; her value is in being a suitable pick for a wife, vessel for reproduction and catering to the needs of the man. The body then becomes objectified; weight loss or weight gain remains adapted to the self-serving interests and control of the male gender. Self-starvation, food refusal or adopting the resistant meaning centred anorexic body for these women within a cultural repressive environment is regarded as a sign of rebellion against established misogyny. New feminine ideal of beauty is created by consciously and voluntarily adapting the thin body as a feminist symbol of liberation, emancipation and control. The meaning centred anorexic body consciously and voluntarily engages self- starvation and

⁷²⁹ Lamb, *op. cit.*, p.28.

⁷³⁰ Sunday Standard, *op. cit.*

⁷³¹ Ghosh, *op. cit.*

⁷³² British Broadcasting Corporation, *op. cit.*

⁷³³ *Ibid.*

thinness as a symbol of self-determination, autonomy and control over their *body* and self.

Offsetting socio-cultural pressure to be thin can be done by autonomous regulations of eating patterns.⁷³⁴ In the UK, the idea that individuals are given the freedom to regulate the way their body changes and develops through controlled eating can intensify thin body internalisation however the negative end of this perceived pressure can be evaluated on both end of the spectrum - impose a resistance not to conform to the pressure to stay thin or increase the dissatisfaction with the scrutiny and control of what the ideal female body should be. The disparity reveals an underlying patient centred thin body ideals conformation, which can only manifest in a meaning centred resistant body only when the individual is involuntarily force-fed to address the physical emaciation. Nigeria, on the other hand, reveals a remarkable case of increased dissatisfaction with the socio-cultural pressure on women to reveal more curves rather than thinness. Banks insists that anorectics should utilize precise cultural symbols and belief system in other to offer meaning to their underlying conscious choice of self-starvation.⁷³⁵ Directly engaging cultural symbols and belief systems is one way to reveal meaning. However, a second pathway will involve the anorexic body acknowledging the existence of these cultural patterns and beliefs then resisting societal or medical control imposed by the existing culturally engraved behaviour to provide more explicit meaning centred sense.⁷³⁶ A productive approach will ensure the conscious elements necessary to sustain the meaning centred anorexic body are present. The best way is to guarantee consciousness of their self-starvation ideals to ensure a clear version and interpretation of the symptoms of self-starvation, which are

⁷³⁵ Banks, *op. cit.*, pp.868-869.

⁷³⁶ *Ibid.*

exclusively different from accounts of medical practitioners and diagnosticians.⁷³⁷ Epner and Baile insist that the dynamic nature of culture includes fundamental themes such as attitudes, beliefs and behavioural pattern to engage the underlying meaning behind the symptoms.⁷³⁸ There is also the notion that most women's understanding of their self-starvation and thinness excludes mental illness, thus there is an outright rejection of medical diagnosis and intervention to further treatment.⁷³⁹ Banks therefore believes the apparent lack of triumph by clinicians in treating anorexics might be because of clinical failure of including "the anorectics own subjective meanings – and the role of culture in those meanings – into account".⁷⁴⁰

Pushkar recalls that the insensitivity towards the role of culture on the experience of illness meant that clinicians will have no knowledge of the nature of patients value.⁷⁴¹ On the other hand, Kirmayer notes that focus on culture has not evolved the dominant patterns in clinical practice, which disregards the impact of culture, and traditions in framing human problems⁷⁴² whether negatively or positively. Wachtel agrees with Kleinman's view that the limitations imposed by narrow-minded theories and practices offer no significant pathway in resolving the complexities of human nature. Perhaps further questions should be raised "about how much our own practices are based on science and how much are on unexamined cultural values".⁷⁴³ Gorski, on the other hand, insists that the main perspectives of Kleinman unmasked the use of

⁷³⁷ *Ibid.*

⁷³⁸ Daniel E. Epner and Walter F. Baile, 'Patient-Centered Care: The Key to Cultural Competence' (2012) 3(23) *Annals of Oncology* p.33.

⁷³⁹ Banks, *op. cit.* pp.868-869.

⁷⁴⁰ *Ibid.*

⁷⁴¹ Piyush Pushkar, 'Rethinking Psychiatry: From Cultural Category to Personal Experience by Arthur Kleinman' (2011). 342 (7810) *British Medical Journal* p.1315.

⁷⁴² Lawrence J. Kirmayer, 'Rethinking Cultural Competence' (2012) 49(2) *Sage Journal* p.151.

⁷⁴³ Paul L. Wachtel, 'Around the World in a Couch: Rethinking Psychiatry from Cultural Category to Personal Experience' *New York Times* 4th September 1988 p.237.

medicalization as a form of social system. Secondly, by applying evidence derived from non-western cultures, recognition of the universality of disorders will emerge deposing established western bias of limiting symptoms to a particular culture. Lastly, although there was lack of specific gender (feminist) focus, there are still illuminating conceptions on culture and its impact on individual experience.⁷⁴⁴

Kleinman recognised the importance of social norms and cultural meaning as an integral interpretation of an individual's experience.⁷⁴⁵ Ignoring these vital experiences whilst focusing on clinical diagnostic features remarkably undervalues their historic individualized cultural history and discontinues the opportunity for future narratives on their state of being.⁷⁴⁶ The biological and physical elements are intertwined and connected with daily experience and cannot be separated in practice.⁷⁴⁷ Clinicians working with ethnic diverse patients would have to acknowledge the value of cultural influence on their experience and as a result such values should form part or whole in analysing underlying symptoms. Regardless of existing counterfactual options, individual experiences are significant in accounting for diagnostic symptoms however the reason these experiences are not relied upon to reveal the underlying meaning raises serious questions. The first step is to recognise the individual, which fundamentally work against the medical mechanism of broad categorisation or labelling. Under this umbrella, should all individual who exhibit cross-demographic symptoms of anorexia be categorised as mentally ill? If not, can recognizing a cross-cultural meaning centred- variation enable clinicians to

⁷⁴⁴ Victoria Gorski, 'Review of Thinking Psychiatry: From Cultural Category to Personal Experience' (1991) 9(2) Families, Systems and Health Journal pp.193-195.

⁷⁴⁵ Arthur Kleinman, *Rethinking Psychiatry: From Cultural Category to Personal Experience* (New York, Simon and Schuster 1970) p.23.

⁷⁴⁶ *Ibid.*

⁷⁴⁷ *Ibid.*

acknowledge a set of post-modern narrative which exist outside the diagnostic manual where if A is labelled A, it then must be A. Good and Good point out the biomedical models are overwhelmed by “epistemological and practical difficulties” given the restrictive approach which does not include a “cultural patterning of symptoms” in clinical practice.⁷⁴⁸ Invariably the problem with the biomedical approach is that complaints are not received and heard as part of the experiences neither are they converted into evidence for solutions rather there is an antagonism to maintain a status-quo befitting the existing medical model. In *Re X, R, E*, the underlying issue was a clear demonstration of overdependence on the strict criteria of clinical practice and reliance on clinical practice and clinical models to gain insights on the experiences of the anorexic. The limitations of the clinical foresight also became a burden for courts as they often fail to include relative cultural data or acknowledge that social cultural realities are evidenced in the symptoms.

The common feature in the writings of Banks and Schwartz et al⁷⁴⁹ identified that the issues in understanding contemporary anorexia nervosa extends beyond identifying cultural attributes in culture bound syndromes but also the understanding and application of the individual’s values and norms. Identifying the values and norms proffers the eroded subjective meaning underlying self-starvation. One must also digress from predominant clinical approach to contemporary anorexia focus on self-starvation and physical emaciation, offering no intricate clarifications with cross-cultural bound contexts. Arguably suggestions of increasing legal rights and

⁷⁴⁸ Byron J. Good and Mary-Jo D. Good, ‘The Meaning of Symptoms: A Cultural Hermeneutic Model for Clinical Practice’ L. J. in Eisenberg and A. Klewman (eds.) *The relevance of Social Science for Medicine, Culture, Illness and Healing: Studies in Comparative Cross-Cultural Research* (Dordrech, Reidel Publishing Company) p.165.

⁷⁴⁹ D. M. Schwartz, M.G. Thompson, and C.L. Johnson, ‘Anorexia Nervosa and Bulimia: The Socio-Cultural Context’ (1982) 1(3) *International Journal of Eating Disorders* pp. 20-22.

acknowledging the intricate meaning underneath the veiled mystifying disorder has not gained any substantial development. Perhaps a synchronised evaluation of the physical behaviour and the inner underlying behaviour will provide an illuminating significant demystifying and uncover new rationale of thinking and approach. The missing dimension will co-relate subjective experiences of the body with the reactionary outcome (extreme thinness) which provides the clarity to what thinness means to the anorexic body. Kleinman suggests a rethink of the way individuals were examined by linking cultural ideals with experience, limiting biological explanation and rearranging western psychiatric bias where “psychosocial and cultural factors are considered merely epiphenomenal”.⁷⁵⁰ Therefore, accepting Kleinman’s theoretical concession which insists that there are varying misguided assumptions which offer no meaning or interpretation to the natural state of the individual will require a genuine adaptation to viewing “psychiatric diagnosis as fundamentally an interpretative act” conceived from experiences, moral and norms and translated into “theoretical model of pathology and disease”.⁷⁵¹ Likewise, the experiences of an individual cannot be separated from their way of life, the society they dwell in and their immediate nuclear family.⁷⁵² Thus with the idea that there is a link between a person’s relationships and the mental state and recognising that self-expression are key components of experiences thereby demanding an empathic comprehension of an individual live as well as the diagnosed symptoms.⁷⁵³ Advancing towards a broader cultural inclusion of experience tied to culture and society, clinicians would have to admit a certain level of conscious decisions and competence to an experience. Acknowledging a cultural significant meaning centred experience as a core feature in self-starvation implicitly

⁷⁵⁰ Kleinman, *op. cit.*

⁷⁵¹ *Ibid.*

⁷⁵² Meredith F. Small, *The Culture of our Discontent: Beyond the Medical Model of Mental Illness* (Washington D.C, Joseph Henry Press 2006) p.149.

⁷⁵³ *Ibid.*

establishes a moral symbolism absent in clinical practice and validates that notion that “cultural norms all have a huge impact on individuals’ mental health”.⁷⁵⁴ Weight loss therefore becomes a secondary outcome.

Social, religious and political contexts to eating disorders are undervalued and predominately not examined within neutral cultures unaffected by western ideals.⁷⁵⁵ Multiple research outside non-western cultures reveal departure from the standardised criteria of western anorexic ideals based on the fear of weight gain and body image distortion. Remarkably, it has been established that non-western cultures are also unfamiliar with the concept of anorexia, as it exists in biomedicine. Therefore, analysing anorexia under a particular culture would not be based on the typical western features of fear of weight gain or fat phobia instead there would be need to explore beyond set boundaries as anorexia may present a different outlook even if not diagnosable. The challenge is to present anorexia nervosa within a non-medical platform unfulfilling of the singular criterion of extraordinary fear of weight gain. In other words, to obtain significant meaning, it is imperative to explore cultures where self-starvation is voluntary and self-induced and the fear of weight gain is not a fundamental attribute of anorexia.⁷⁵⁶ Barring the western features, focus would be redirected to how dramatic weight loss is sustained through other elements such as “...social protests and spiritual purification, which are defining features of other contexts in which fasting and self-starvation occur...”.⁷⁵⁷ Weiss therefore asserts:

⁷⁵⁴ Small, *op. cit.*, p. 149-150.

⁷⁵⁵ Weiss, *op. cit.*

⁷⁵⁶ Sing Lee, ‘Anorexia Nervosa in Hong Kong: A Chinese Perspective’ (2009) 21(3) Psychological Medicine pp.703-711.

⁷⁵⁷ Weiss, *op. cit.* p.15.

“Self-starvation may provide a means to exercise power and control in families and society. Anorexia represents a subset of broader range of self-starvation behaviors that include expressions of social and political protests, self-purification and religious piety.”⁷⁵⁸

Anorexia will continue to present critical challenges for treatment professionals especially given the rise of multicultural groups identifying distinctive features within local meaning, thus necessitating the inclusion of a “diagnostic criteria suitable for cross-comparisons”.⁷⁵⁹ Nicholas therefore points out that actions outside the psychiatric discourse can therefore be better understood as a political act, “a space of action where one grapples with discourses and structures of notions of starvation among women”.⁷⁶⁰ In establishing a meaning centred approach to self-starvation, there is a normative dieting implication subjectively associated with the experiences of the anorectic.⁷⁶¹ The meaning centred anorexic body consciously elects to self-starve, restrict eating and exercise excessively (all stereotypical symptoms of anorexia) with the following aim: (1) to fully manage the way their body changes and develops without any external interference or control; (2) as defence mechanism over previous negative physical, psychological and mental experience; (3) assert the rights to autonomy and bodily integrity; (4) rebellion against the misogyny of African men towards the skinny woman as they rather embrace the curvy and well-rounded woman. Weiss therefore suggests a cultural clarification of the illness using research

⁷⁵⁸ *Ibid.*, p.13.

⁷⁵⁹ *Ibid.*, p.15.

⁷⁶⁰ Jane Nicholas, ‘Hunger Politics: Towards Seeing Voluntary Self-Starvation as an Act of Resistance’ (2008) 8(1) *Journal of Feminist Theory & Culture* available at <http://journals.sfu.ca/thirdspace/index.php/journal/article/view/nicholas/215> [accessed 11th February 2018].

⁷⁶¹ Banks, *op. cit.*, p.867.

instruments to analyse local meanings to provide insights, highlight experiences and explain traditional epidemiology. Empirical work carried out will therefore centre on individuals within the local communities who engage in self-starvation or extreme fasting without the fear of weight gain or body distortion.⁷⁶²

5.1.1 Objectives of the Study Carried out in Nigeria

The study seeks to verify the meaning centred theory of the anorexic body and specifically focuses on:

1. Examining the relationship between self-starvation, food refusal and mental illness;
2. Examining the role food restriction plays in the individuals' perception of their body and freedom of choice;
3. Determining meaning non-western culture attribute to their anorexic body;
4. Establishing that self-starvation and extreme thinness can be done consciously and with reason. Hence, there is a meaning centred variation to this experience;
5. Establishing that self-starvation and fat phobia is not ordinarily linked to mental illness except when reinforced by the law;
6. Devaluing the universal stereotype that extreme thin body signifies mental illness; and
7. Establishing that typical features of anorexia can be identified within local meaning.

⁷⁶² *Ibid.*

5.1.2 Research Methodology

The study examines the relationship between anorexic body and mental illness in Cross River State, Nigeria. The possible causes and the extent of satisfaction derived from the anorexic body were also examined. The research design, research area, population of the study, sample and sampling technique are all set out below. This chapter also discusses the instrumentation including validity and reliability of the instruments, and data collection procedure.

5.1.2.1 Research Design

The design adopted for this study is the survey design. It involved gathering data from the whole of Cross River State in Nigeria on the relationship between two variables. The variables are the anorexic body and mental illness. The researcher does not have direct control over the manifestation of the variable as they have already occurred prior to her investigation and therefore manifestation cannot be altered. Therefore, the empirical work seeks to find out the kind or extent of relationship that exists between them. Young females aged 18 years and above were selected from the whole of Cross River State, in Nigeria. Cross River State covers a very large area and the population of females with anorexic body is equally large. Only a small percentage of these females were selected for this study.

5.1.2.2 Research Area

The research area for this study is Cross River State. Cross River State is one of the 36 states in Nigeria. It is located in the South-South geo-political zone of the Federal Republic of Nigeria with the capital in Calabar. Cross River State is located within latitudes 5°32' and 4°27' North of the Equator as well as longitudes 7°50' and 9°28'

East of the Greenwich meridian. The state covers a land mass of 23,074,425 square kilometres. The state has a population of 2,888,966⁷⁶³ people comprising 1,492,465 males and 1,396,036 females.⁷⁶⁴ Cross River State shares boundaries with the Republic of Cameroon in the East; Ebonyi and Abia States in the West, Benue State in the North, as well as Akwa Ibom State and the Bight of Bonny in the South. Several tertiary institutions are situated in Cross River State. These include the University of Calabar, Calabar; Cross River University of Technology (CRUTECH) with multi-campus; Arthur Jarvis University, Akpabuyo; College of Education, Akamkpa; Federal College of Education, Obudu; College of Health Technology, Calabar; Management Development Institute, Calabar; Institute of Management Technology, Ugep; School of Nursing, Calabar; and School of Midwifery, Calabar. All these tertiary institutions have large population of females. Many of these females have extremely thin bodies. Hence, this area is suitable for this study. Customarily, the majority of women from this area are fat and well rounded. The fattening room is a core tradition in this area and originated from the age-long traditions of secluding women in huts for fattening and preparation for a successful marriage and motherhood.⁷⁶⁵ One of such ceremonies was keeping brides in fattening rooms where the brides are provided with special diets and care. The aim of this confinement was to develop curvy bodies which should make them very attractive to their suitors.

⁷⁶³ Joseph G. Ottong, Simon O. Ering and Felix U. Akpan, 'The Population Situation in Cross River State of Nigeria and its Implication for Socio-economic Development: Observations from the 1991 and 2006 Censuses' (2010) 1 (1) *Journal of Emerging Trends in Educational Research and Policy Studies* pp. 36-42.

⁷⁶⁴ Cross River State Ministry of Information, Youths and Sports, *Dairy* (Lagos, Congrats Publications 1998).

⁷⁶⁵ Victor J. Etuk 'A Tribe's Fattening Culture and its Impact on Health' (2014) available at <https://hekint.org/2017/01/29/a-tribes-fattening-culture-and-its-impact-on-health/> [accessed 9th April 2018].

5.1.2.3 Population of the Study

The population of the study includes all female students in tertiary institutions in Cross River State, Nigeria who are extremely thin. This study was restricted to only students who are aged 18 years and above.

5.1.2.4 Sample

The sample was made up of one thousand (1000) students from the tertiary institutions aged 18 years and above. It also includes only the students who are physically extremely thin.

5.1.2.5 Sampling Technique

Simple random and purposive sampling techniques were adopted for the selection of the respondents. Out of the ten (10) tertiary institutions in Cross River State, Nigeria, five (5) were randomly selected. These include University of Calabar, Calabar; Cross River University of Technology (with multi-campus); College of Education, Akamkpa; Federal College of Education, Obudu; and College of Health Technology, Calabar. Since it was not possible to know the exact population of the extremely thin females in each institution, 5% of the female students were selected, using the purposive sampling technique. This purposive sampling technique was to ensure that only the extremely thin female students were selected.

5.1.2.6 Instrumentation

The researcher constructed the instrument used for this study. It was titled “Meaning Centered Anorexic Body Questionnaire” (MCABQ). Minnesota Multiphasic Personality Inventory (MMPI) format was adopted for the construction of the instrument. The respondents were required to answer “YES” or “NO” to the statements in the questionnaire. The items were extracted from the literature and experience with characteristics of people with anorexic body. The questionnaire consists of four sections – A, B, C and D. Section A elicited responses from the respondents concerning their demographic data, such as institution, age and body size while Section B consisted of 11 items and sought to find out the relationship between the anorexic body and mental illness (items 1-11). Section C was to know how contented the respondents were, with their anorexic body. It was made up of 8 items (items 12-19). Section D, which was made up of 13 items, was to elicit responses concerning reasons for assuming the anorexic body (items 20-32). For each item, the “YES” answers were scored 1 while the “NO” answers were scored 0. The instrument contained instruction that the questionnaire was for research purpose and so, there were no wrong answers. They were equally instructed not to write their names. They were to remain anonymous, and independent.

5.1.2.7 Validity of the Instrument

The researcher made effort to ascertain the ability of the research instrument to determine what it was supposed to measure at any given time. The developed research instrument was presented to two experts in Measurement and Evaluation and three experts in psychology for validation. Each of these experts received a copy of the

MCABQ. The experts were to critically examine the content of the study and the extent to which the statement was appropriate for the study. After examining the instrument, the experts identified some minor errors, which were corrected.

5.1.2.8 Reliability of the Study

To ensure the instrument was consistent, dependable and predictable, it was trial-tested to determine its internal consistency. Copies of the MCABQ were administered on 30 female students with anorexic body, in one of the tertiary institutions that was not included in the actual study, for the trial-testing. The Cronbach alpha technique was used to determine the reliability coefficient. The results are as presented in Table 1.

TABLE 1

Cronbach alpha reliability coefficient of the research instrument (n = 30)

Variable	No. of items	Mean	SD	A
Anorexic body association with mental illness	11	3.54	2.75	0.78
Contentment with the anorexic body	8	2.86	2.21	0.75
Reasons for assuming the anorexic body	13	8.48	3.40	0.83

The results on Table 1 show that the reliability coefficient ranged from 0.78 for the anorexic body association with mental illness through 0.75 for contentment with the anorexic body to 0.83 regarding reasons for assuming the anorexic body. Since all the coefficients are very high, it means the instrument is very reliable.

5.1.2.9 Data Collection Procedure

The researcher wrote a letter to the selected institutions seeking permission to use their students for the study and asked for their written response (Appendix 1). Research assistants were used to collect the data. These research assistants were trained on courtesy, ethics of administration and knowledge of terms and phrases involved in the study. The research assistants were sent to institutions far from the researcher while the researcher administered the copies of the MCABQ on the respondents for the institutions close to the researcher. The researcher and the research assistants urged the respondents to work independently. Copies of the completed MCABQ were collected immediately.

5.1.2.10 Procedure for data analysis

The data from all the 1000 female students with anorexic body (BMI 17.5 and below) were collected and analysed. Each research question was analysed using frequencies and percentages for the statements, as they required “Yes” or “No” responses. “Yes” was weighted 1 while “No” was weighted 0.

5.2 Results and Discussion

In this chapter, the results of the data analysis carried out on the data gathered from the field for the study were presented and interpreted. The findings that emerged were discussed. The presentation in this chapter is done under the following sub-headings:

5.2.1 Presentation of findings per research question

5.2.2 Summary of findings

5.2.3 Discussion of findings

5.2.1 Presentation of Findings per Research Question

This research question was answered using frequencies and percentages. Respondents were grouped into two (yes and no) based on their responses to items 1-11 of Section B of the research instrument. The results are presented in Table 2.

TABLE 2

Extremely thin body (anorexic body) association with mental illness

S/No	Statement	Yes (%)	No (%)	Mean
1	Do you associate your extreme thin body with mental illness?	88 (8.8)	912 (91.2)	0.09
2	Do you associate your self-starvation to mental illness?	191 (19.1)	809 (80.9)	0.19
3	Are you able to function well (work, carry on everyday life) while assuming this extremely thin body?	848 (84.8)	152 (15.2)	0.85
4	Do you believe this is a form of exercising your freedom or autonomous right?	746 (74.6)	254 (25.4)	0.75
5	Do you exercise regularly to retain this thin body?	613 (61.3)	387 (38.7)	0.61
6	Do you associate the expression of freedom to preserve your bodily integrity with mental illness?	399 (39.9)	601 (60.1)	0.40
7	Are you conscious or aware of your choice to become thin?	649 (64.9)	351 (35.1)	0.65
8	Are you conscious or aware of your choice to remain thin?	635 (63.5)	365 (36.5)	0.64
9	Have you been involuntarily treated?	179 (17.9)	821 (82.1)	0.18
10	Do your friends laugh at you because of your thin body?	295 (29.5)	705 (70.5)	0.30
11	Does any of your family members consider you ill?	270 (27.0)	730 (73.0)	0.27

The results as presented in Table 2 show the respondents' responses to whether their thin body (anorexic body) associates with mental illness. The result revealed that 88 of the respondents representing 8.8% agreed that they associate their extreme thin body with mental illness while 912 of them representing 91.2% disagreed to that and

the result produced a mean of 0.09. It was also observed that 191 of the respondents representing 19.1% agreed that they associate their self-starvation to mental illness while 809 of them representing 80.9% disagreed to that and the result produced a mean of 0.19. It was further observed that 848 of the respondents representing 84.8% agreed that they are able to function well (work, carry on everyday life) while assuming this extremely thin body while 152 of them representing 15.2% disagreed to that and the result produced a mean of 0.85. Further examination of the result revealed that 746 of the respondents representing 74.6% agreed that they believed that this is a form of exercising their freedom or autonomous right while 254 of them representing 25.4% disagreed to that and the result produced a mean of 0.75. It was also observed that 613 of the respondents representing 61.3% agreed that they exercise regularly to retain their slim body while 387 of them representing 38.7% disagreed to that and the result produced a mean of 0.61. It was further observed that 399 of the respondents representing 39.9% agreed that they associate the expression of freedom to preserve their bodily integrity with mental illness while 601 of them representing 60.1% disagreed to that and the result produced a mean of 0.40. Furthermore, the result revealed that 649 of the respondents representing 64.9% agreed that they are conscious or aware of their choice to become thin while 351 of them representing 35.1% disagreed to that and the result produced a mean of 0.65. It was also observed that 635 of the respondents representing 63.5% agreed that they are conscious or aware of their choice to remain thin while 365 of them representing 36.5% disagreed to that and the result produced a mean of 0.64. It was further observed that 179 of the respondents representing 17.9% agreed that they have been involuntarily treated while 821 of them representing 82.1% disagreed to that and the result produced a mean of 0.18. It was further observed that 295 of the respondents

representing 29.5% agreed that their friends laugh at them because of their thin body while 705 of them representing 70.5% disagreed to that and the result produced a mean of 0.30. The result finally revealed that 270 of the respondents representing 27.0% agreed that their family members consider them ill while 730 of them representing 73.0% disagreed to that and the result produced a mean of 0.27.

Table 3

This research question was answered using frequency and percentages. Respondents were grouped into two (yes and no) based on their responses to items 12-19 of Section B of the research instrument. The results are presented in Table 3.

TABLE 3
Contentment with the Anorexic Body

SN	Statement	Yes (%)	No (%)	Mean
12.	Has anyone advised you to go for medical treatment because of your thin body?	215 (21.5)	785 (78.5)	0.22
13.	If possible, would you like to become thinner?	170 (17.0)	830 (83.0)	0.17
14.	If advised by a clinician, would you change your body size?	368 (36.8)	632 (63.2)	0.37
15.	Are there occasions you regret the anorexic body?	307 (30.7)	693 (69.3)	0.31
16.	Would you change your extremely thin body to a normalized body in the future?	421 (42.1)	579 (57.9)	0.42
17.	Would you advise your plump friends to become extremely thin within meaning?	620 (62.0)	380 (38.0)	0.62
18.	Do you feel any physical weakness as a result of being extremely thin?	197 (19.7)	803 (80.3)	0.20
19.	Do you ever feel the urge to cover up part of your body out of embarrassment?	339 (33.9)	661 (66.1)	0.34

The results as presented in Table 3 show the respondents' responses on how comfortable they are about their thin body (anorexic body). The result revealed that 215 of the respondents representing 21.5% agreed that someone has advised them to go for medical treatment because of their thin body while 785 of them representing 78.5% disagreed to that and the result produced a mean of 0.22. It was also observed that 170 of the respondents representing 17.0% agreed that if possible, they would like to become thinner while 830 of them representing 83.0% disagreed to that and the result produced a mean of 0.17. It was further observed that 368 of the respondents representing 36.8% agreed that if they were advised by a clinician, they would change their body size while 632 of them representing 63.2% disagreed to that and the result produced a mean of 0.37.

Further examination of the result revealed that 307 of the respondents representing 30.7% agreed that occasionally they regret their anorexic body while 693 of them representing 69.3% disagreed to that and the result produced a mean of 0.31. It was also observed that 421 of the respondents representing 42.1% agreed that they would change their extremely thin body to a normalized body in future while 579 of them representing 57.9% disagreed to that and the result produced a mean of 0.42. It was further observed that 620 of the respondents representing 62.0% agreed that they would advise their plump friends to become extremely thin within meaning while 380 of them representing 38.0% disagreed to that and the result produced a mean of 0.62.

Furthermore, the result revealed that 197 of the respondents representing 19.7% agreed that they feel some physical weakness as a result of being extremely thin while 803 of them representing 80.3% disagreed to that and the result produced a mean of 0.20. It was finally observed that 339 of the respondents representing 33.9% agreed

that most times they feel the urge to cover up part of their body out of embarrassment while 661 of them representing 66.1% disagreed to that and the result produced a mean of 0.34.

TABLE 4

This research question was answered using frequency and percentages. Respondents were grouped into two (yes and no) based on their responses to items 20-32 of Section D of the research instrument. The results are presented in Table 4.

TABLE 4

S/N	Statement	Yes (%)	No (%)	Mean
20.	Take control of my body?	823 (82.3)	177 (17.7)	0.82
21.	Resistance against cultural oppressive regime?	578 (57.8)	422 (42.2)	0.58
22.	Expression of freedom (autonomy) over my body?	739 (73.9)	261 (26.1)	0.74
23.	Mental illness?	119 (11.9)	881 (88.1)	0.12
24.	Previous experience of a non-thin body?	614 (61.4)	386 (38.6)	0.61
25.	Experience of others with non-thin body?	582 (58.2)	418 (41.8)	0.58
26.	I have been involuntarily treated because of my extreme thin body.	244 (24.6)	756 (75.6)	0.25
27.	The Nigerian environment provides the freedom to express my autonomous right without the stereotype of mental illness.	670 (67.0)	330 (33.0)	0.67
28.	The Nigerian environment provides the freedom for control over my body without the stigma of mental illness.	695 (69.5)	305 (30.5)	0.70
29.	To resist the cultural ideal beauty (regarding fat body as a sign of beauty)	618 (61.8)	382 (38.2)	0.62
30.	To be admired more by the opposite sex?	392 (39.2)	608 (60.8)	0.39
31.	Physiological/Medical ground	337 (33.7)	663 (66.3)	0.34
32.	Because being extremely thin is not a mental illness.	720 (72.0)	280 (28.0)	0.72

The results as presented in Table 4 show the respondents' response about their choice to become thin or assume the anorexic body. The result revealed that 823 of the respondents representing 82.3% agreed that it is to take control of their body while 177 of them representing 17.7% disagreed to that and the result produced a mean of 0.82. It was also observed that 578 of the respondents representing 57.8% agreed that it was because of resistance against cultural oppressive regime while 422 of them representing 42.2% disagreed to that and the result produced a mean of 0.58. It was further observed that 739 of the respondents representing 73.9% agreed that it was expression of freedom (autonomy) over their body while 261 of them representing 26.1% disagreed to that and the result produced a mean of 0.74.

Further examination of the result revealed that 119 of the respondents representing 11.9% agreed that it was as a result of mental illness while 881 of them representing 88.1% disagreed to that and the result produced a mean of 12. It was also observed that 614 of the respondents representing 61.4% agreed that it was because of previous experience of a non-thin body while 386 of them representing 38.6% disagreed to that and the result produced a mean of 0.61. It was further observed that 582 of the respondents representing 58.2% agreed that it was as a result of experience of others with non-thin body while 418 of them representing 41.8% disagreed to that and the result produced a mean of 0.58. Furthermore, the result revealed that 244 of the respondents representing 24.4% agreed that they have been involuntarily treated because of their extreme slim body while 756 of them representing 75.6% disagreed to that and the result produced a mean of 0.25. It was also observed that 670 of the respondents representing 67.0% agreed that the Nigerian environment provides the

freedom to express their autonomous right without the stereotype of mental illness while 330 of them representing 33.0% disagreed to that and the result produced a mean of 0.67. It was further observed that 695 of the respondents representing 69.5% agreed that the Nigerian environment provides the freedom for control over their body without the stigma of mental illness while 305 of them representing 30.5% disagreed to that and the result produced a mean of 0.70. It was further observed that 618 of the respondents representing 61.8% agreed that it was to resist the cultural ideal beauty (regarding plump body as a sign of beauty) while 382 of them representing 38.2% disagreed to that and the result produced a mean of 0.62. The result also revealed that 392 of the respondents representing 39.2% agreed that it was to be admired more by the opposite sex while 608 of them representing 60.8% disagreed to that and the result produced a mean of 0.39. The result further revealed that 337 of the respondents representing 33.7% agreed that it was on the basis of physiological/medical ground while 663 of them representing 66.3% disagreed to that and the result produced a mean of 0.34. The result finally revealed that 720 of the respondents representing 72.0% agreed that it was because being extremely thin is not a mental illness while 280 of them representing 28.0% disagreed to that and the result produced a mean of 0.72.

5.3 Discussion of Findings

5.3.1 Table 2

The finding reveal how the anorexic body interprets disordered behaviour without establishing or accepting the constructions of mental illness. Majority of the respondents (91.2%) did not associate their extreme thin body (anorexic body) with mental illness as against only 8.8% who did so. This finding is supported by other

results indicating that 80.9% of the respondents did not associate their self-starvation and food refusal with mental illness, 84.8% are able to function well; 74.6% believed in their autonomous right; 61.3% continued to exercise regularly to retain their anorexic body. These findings show that Nigerian young women who self-starve, exercise excessively to retain their anorexic body do not feel any sign of ill health to compel them to change their habit. Their life activities are not hindered by any physical or psychological factors to disrupt their daily function as they said they function well. Since these young women are functioning well without any sign of ill health or psychological and physical factors that could hinder their life activities, it means they were qualified to be seen as being healthy. Illness conditions of chemical and cellular experiences or observation of any underlying psychochemical processes are lacking. Udin and Lewis had state that one could only be described as being ill if such a person manifests some physical and psychological symptoms.⁷⁶⁶The person is likely to manifest the symptoms of disease, which is defined in chemical and cellular terms, with the hope that the observable symptoms could also be related to some underlying physiochemical processes.⁷⁶⁷

Udin and Lewis also point out that conditions of illness goes beyond physical defects or the physiochemical processes to include behavioural problems triggered by environmental factors surrounding and influencing the individual. Since the respondents in this study did not experience any such environmental problems, it should be acceptable if they say they do not associate their anorexic body (thin body) with mental illness. In addition, if one accepts the definition of mental health as propounded by Gottesfeld, it would further strengthen the position of the respondents

⁷⁶⁶ Gene Udin and Lewis J. Lewis, *Psychiatry in General Medical Practice* (New York: McGraw-Hill 1979). p.47.

⁷⁶⁷ *Ibid.*

in this study. Gottesfeld explains that mental health can be viewed as the positive striving as a person grows, matures and accepts responsibilities, including coping successfully and finding fulfilment.⁷⁶⁸ Invariably, it could be inferred that majority of the respondents were growing, maturing and accepting responsibility through their positive striving.⁷⁶⁹ This becomes even more acceptable as they claimed they were functioning well. That means the respondents can be seen as being mentally healthy, even as Gottesfeld added that mentally healthy people should develop intellectual abilities, work skills and social sensitivity. The respondents could have possessed the three fundamental aspects of mental health.⁷⁷⁰ The identified three fundamental aspects of mental health include active adjustment involving attempts to master their environment; unity of their personality and stable integration of experiences; as well as the correct perception of the world and self, irrespective of personal needs.⁷⁷¹

Vasta, et al noted some of the effects of anorexia nervosa patients' experience which include dry skin, dry and brittle hair, and dehydration.⁷⁷² The individuals involved in this study were not observed to be experiencing these problems. The hair of each of them was observed to be normal. The same applies to their skin. Their skins were fresh and well nourished. None of the persons involved in the study was observed to be dehydrating. Since these illness conditions were not observed among the respondents, it will be wrong to evaluate them within the standard medical definition of anorexia nervosa which will reinforce the mentally ill narrative. These include depression, problem with the mood, social withdrawal and low self-esteem, which become more prevalent for groups that value their weight and appearance highly, such

⁷⁶⁸ Gottesfeld, *op. cit.* p.11.

⁷⁶⁹ *Ibid.*

⁷⁷⁰ *Ibid.*

⁷⁷¹ *Ibid.*

⁷⁷² Vasta, *et al, op. cit.*

as the fashion models. Even though it was not possible to know if any of the people involved in this study were fashion models, the fact is that none of them was observed to be experiencing these problems stated here. They all looked bright, cheerful and cooperative. They did not display signs to suspect any of them was depressed and involved in low self-esteem as they appeared to value themselves highly, at least, judging from their pattern of dressing.

The finding that majority of the respondents did not associate self-starvation and food refused with mental illness shows that Nigerian young women who self-starve could be undergoing one of such periods they pass through in the course of exerting control over their body to avoid weight gain, especially as 74.6% of them believe it is their autonomous rights. Gleitman believes that some women are interested in controlling their weight in order to show they have some degree of autonomy and control over their body.⁷⁷³ The freedom to preserve their body in the way they choose cannot then be conceived as mental illness. Self-starving, therefore does not automatically translate to mental illness. This becomes clear if one is aware of the differences between voluntary starvation and anorexia nervosa. Sarason and Sarason point out that there are psychological and behavioural differences.⁷⁷⁴ On the mood or feeling state, there is lack of initiative on the part of the person that is starving. Such a person is quarrelsome, indecisive, loses concern about physical appearance while it is not so for the person suffering from anorexia nervosa. The anorexic is characterized by high initiative, strong will, frequent period of feeling exuberant and proud in personal appearance. On the issue of mental content, the person who voluntarily starves is characterized by thinking, dreaming and day-dreaming concerning eating food, while

⁷⁷³ Gleitman, *op. cit.*

⁷⁷⁴ Sarason and Sarason, *op. cit.*

in anorexia nervosa the person has all the listed characterises for starvation, but is not preoccupied with the thought of gaining weight which continues after the person resumes eating. Finally, sexual activity is characterized by decrease in sexual fantasies, feeling of disinterest, inability to maintain erection for the males, and cessation of menstruation for the females. The finding that 61.3% of the respondents did not stop to exercise regularly shows the respondents did not actually perceive any form of mental illness. They were really functioning well and enjoyed the process. People exercise to become healthier and physical health educators do not relent in their emphasis on maintaining good health through regular physical exercises. Therefore, these respondents were aiming at becoming healthier rather than falling ill.

The findings further showed that majority of the respondents do not associate their freedom to preserve their body integrity with mental illness (60.1%); are aware or conscious of their desire to become thin (64.9%); are conscious of their choice to remain thin (63.5%); have never been involuntarily treated (82.1%); friends do not laugh at them (70%); and family members do not consider them ill (73%). Many of the fashion models prefer thin body to fat one as their employers and sponsors would want them to be. This also applies to beauty pageant contestants, ballet dancers, etc. that are very passionate about their weight and physical appearance.⁷⁷⁵ Such females in these groups are often from the middle and upper socio-economic class of the society. They have been made to accept thinness as the attractive feminine physique. It could have been this belief that made them pursue thinness, as the ideal feature so maintaining this feature of thinness would be to maintain the respondents' thin body integrity. They would not want to deviate from what they consider the societal norm

⁷⁷⁵ Gross, *op. cit.*

for their class as they might be treated with contempt, if they do. It therefore becomes obvious that they approach the loss of weight with consciousness to exercise their freedom to preserve their body integrity and would consciously remain so.

That friends do not laugh at them (70%) and family members do not consider them mentally ill (73%) explain why they should not consider themselves mentally ill. This could be attributed to the fact that they are getting on well with their friends and family members. It would be irrational for these friends and family members to consider them mentally ill for losing weight. For the respondents to be declared mentally ill or anorexic, it is necessary to find out if their body weight is not within the normal range.⁷⁷⁶ The person's body weight must not be less than 85 percent which is considered normal for that person's height and age. Therefore, it is not all the young females that lose weight or possess the anorexic body that are mentally ill. This is further supported by the fact that only a small percentage of such people actually meet the criteria for anorexia nervosa.

Alloy, et al also add that for anybody to be diagnosed as anorexic, that person must possess the following indicators: weight loss, a cut-off line of a body weight that is less than 85 percent of what is normal for that particular person's age and height.⁷⁷⁷ This condition may be because of the person's weight or when the person is simply growing without gaining weight in the process.⁷⁷⁸ They also added intense fear of becoming fat, an unrealistic body image, and amenorrhea which means suspension of menstrual period, as other criteria. They insist that no one should be regarded as possessing anorexia nervosa if any of these is absent. Since the respondents were not

⁷⁷⁶ Coon and Mitterer, *op. cit.*

⁷⁷⁷ Alloy, *et al*, *op. cit.*

⁷⁷⁸ *Ibid.*

subjected to these tests, it is wrong to regard any of them as mentally ill.⁷⁷⁹ Gleitman, et al also note the incidence of anorexia nervosa among adolescents and young women.⁷⁸⁰ They put it at 1 percent of these young females from industrialized countries. This is the case even though many of them are involved in relentless pursuit of food refusal or self-starvation. This study finds that majority of the respondents with anorexic body (thin body) did not consider themselves mentally ill. It should also be noted that more weight loss attracts the approval of close friends and family members. They even go ahead to commend them for a new attractive look. This could have made them appreciate their new look without seeing it as a mental illness. That 82.1 percent of the respondents stated they have never been involuntarily treated could have resulted from the provision of Nigerian laws. Unlike in the United Kingdom where anorexia nervosa is a mental illness (Mental Health Act, 1983), Nigerian Mental Health Act 1991 and policies do not recognize it as a mental illness. So Nigerian young women do not associate their freedom to preserve their body integrity with mental illness. Thus, they remain conscious of their actions. Being conscious of their actions suggests they construct their body image and would know when to stop. Observing many Nigerian women shows that they do not continue excessive exercise and self-starvation after their childbirth. Since the Nigerian Medical Health Act 1991 and policies do not recognise anorexia nervosa as a mental illness, people with the anorexic body cannot be treated without their consent. Invariably any act to coerce the anorexic body to stop starving would amount to an invasion of their right to private life and violation of their bodily integrity. Iheanacho reports that the legal profession can only accept that someone is mentally ill or insane

⁷⁷⁹ *Ibid.*

⁷⁸⁰ Gleitman, *et al*, *op. cit.*

if the person can be so adjudged by a court of law.⁷⁸¹ Invariably it has to be established that the individual lacks the capacity to understand their actions and how those actions impact their lives in general. There is also the premise that the individual is unable to differentiate between what is right and wrong at the time and therefore mentally unstable to choose wisely.⁷⁸² It must therefore be demonstrated that the person was labouring under a defect of reason, from the disease of the mind at the time the act was committed which made him or her to fail to understand the nature and quality of the illness committed and therefore cannot act rationally. Citing Schwitzgebel and Schwitzgebel, Iheanacho states the general conditions in law a person must satisfy to be seen as mentally ill. These include: one being dangerous to oneself when left at liberty; being gravely disabled to such an extent of not being able to provide for the one's basic physical needs; when a person lacks sufficient insight or capacity to take responsible decision, regarding hospitalization; and when an individual is in need of care and treatment in a hospital.⁷⁸³

First, the presence of anorexia here is different from the typical cases often reported within the medical model. The women evaluated share the same bodily features (severe emaciation, thinness) and BMI as western anorexic however that is where the comparison ends. The typical features of western anorexia are based on the fear of weight and body distortion. Another valuable criterion is that the BMI of the individuals must be below 17.5 to constitute an anorexic body. Western ideals of beauty standards have fuelled this disorder as women view the thin body as the ultimate standard of beauty unlike the non-western countries. A cross-cultural analysis of the other factors that may constitute anorexia has never been used to

⁷⁸¹ Iheanacho, *op. cit.*

⁷⁸² *Ibid.*

⁷⁸³ Iheanacho, *op. cit.*

engage other variables that might be significant in connection with anorexia and mental illness. The experiences of the majority of Nigerian women in Calabar presents a viable cross-cultural analysis especially as the environment where their lived experience is created are bias towards the thin western ideals. Like other parts of Africa, Calabar is where the fat and curvy woman thrives. The ideal standard of beauty revolves around the desirability of the fat woman as the ultimate symbol of beauty. For women in those communities to elect voluntarily to assume the anorexic body reflects the departure from core western medical narratives of what constitutes anorexia and most importantly how it develops. The implication is that not only is their self-starvation not associated with mental illness, it also reveals that voluntary acts of self-starvation can occur within non-western cultures. Lacking the strict confines of mental health laws and a stereotyped environment, the self-starving individual attains the freedom to live with integrity and dignity without medical coercion or control. DiNicola asserts that cultural connections must be incorporated into analysing anorexia nervosa.⁷⁸⁴ Therefore, anorexia must be seen as beyond mere self-starvation “without reference to context or meaning”.⁷⁸⁵ The cultural identity of the individual is established through the meaning they associate with staying thin as a retributive action to the dominant patriarchal stance of the *fat is better* society they live in. The meaning underling the behavioural approach of the women in Calabar resonates from defining their body image and in so doing challenges the patriarchal ideals dominant in that society. Feminist movements argue that anorexia nervosa represents “a form of political defying against patriarchy. Their fasting is portrayed as

⁷⁸⁴ Vincenzo F. DiNicola, ‘Anorexia Multiforme: Self-Starvation in Historical and Cultural Context: II. Anorexia Nervosa as a Culture-reactive Syndrome’ (1990) 27 *Transcultural Psychiatric Research Review* pp.165-166.

⁷⁸⁵ *Ibid.*

disruptive to the family and society as they disobey norms and distort beauty ideals”.⁷⁸⁶

DiNicola states that overtime it has been established that anorexia nervosa take different forms and in many ways has proven to have “special meaning in modern western cultures”⁷⁸⁷ Note, however, that the standardized difference between hunger strikers and the anorexic body is the legal attitude or framework used to justify force-feeding. In the absence of using mental health law, and justification for security threats (hunger strike), the question is, where does the meaning-centred anorexic body stand outside western culture. The challenge is to determine if like hunger strikers, does the meaning centred anorexic body end once their goal is fulfilled. In the case of the Nigerian woman, this is rather unlikely as their anorexic body is stimulated through experience as a cultural symbol of body discipline and control, which reinforces their autonomy in a patriarchal system. Nicolas considered if the act of resistance is merely concealed as a hunger strike although anorexia remains within the domain of psychiatry. Findings in Calabar reveal that although there is a non-violent protestation through self-starvation, there is no contemporary politically mandated oppression, which is a typical feature of hunger strikers. The issues of preservation of bodily integrity and autonomy do not also arise in the agenda of hunger strikers, as their sole motivation is to fulfil a political agenda and bring awareness to the cause. Hunger strikers therefore fit in within a specific narrative of the political realm. Nicolas however points out that hunger strikers are furnished with legitimacy, which

⁷⁸⁶ Bill of Health, ‘What’s the Difference Between Anorexia Nervosa and Hunger Strike?’ (2015) available at <http://blog.petrieflom.law.harvard.edu/2015/09/23/whats-between-anorexia-nervosa-and-hunger-strike/> [accessed 12th December 2018].

⁷⁸⁷ DiNicola, *op. cit.* p.165.

is not accorded the anorexic body.⁷⁸⁸ Invariably, “the difference lies in audience participation beyond a medical regime of surveillance”.⁷⁸⁹ Perhaps legitimacy comes by adopting a continuum dialogue which present a variation of meanings away from strict clinical monologue. Only then can the meaning-centred anorexic body thrive within their conceptions of beauty, body image and womanhood.

5.3.2 Table 3

The findings revealed that majority of the respondents have not been advised to go for medical treatment because of their thin body (78.5%); would not want to become thinner (83%); would not want to change their body size (63.2%); do not regret having anorexic body (69.3%); would not change their extremely thin body to a normalized body in future (57.9%); would advise their plump friends to become extremely thin within meaning (62%); do not feel any physical weakness as a result of being extremely thin (80.3%); and do not feel the urge to cover up part of their body out of embarrassment (66.1%).

The finding that these respondents with anorexic body have not been advised to go for medical treatment because of their thin body (78.5%) should not be surprising. They have earlier indicated in their responses that they do not associate their anorexic body with mental illness. This applies to their self-starvation. Since they do not associate their anorexic body with mental illness and function very well, it would not be proper to mandate an individual showing no sign of mental illness to go for medical treatment. The findings that they would not want to be thinner (83%), nor would they

⁷⁸⁸ DiNicolas, *op. cit.* p.177.

⁷⁸⁹ *Ibid.*

want to change their body size (63.2%) show the extent of their satisfaction with their anorexic body. They have earlier indicated they chose their anorexic body consciously. They have equally consciously chosen to remain thin and so have gone further to declare the choice not to change their anorexic body in future (57%). These demonstrate their consistency in their responses that they have resolved to retain this anorexic body.

In western cultures, the motivation to become extremely thin is often placed on the media tendency to equate beauty with thinness. So the adolescent becomes very motivated to attain that standard. Attaining that standard, therefore, is a source of satisfaction. These girls could have compared their size or weight with the ideal weight to become satisfied. The ideal weight, obviously, is the weight of the fashion models, ballet dancers and such others. These are the extreme thin girls the western societies portray as beautiful. The Nigerian adolescents and young women are not influenced by the same western ideals portrayed in media advertisements. Normalised or curvy body types dominate the read magazines. Extremely thin women do not also dominate the catwalks or beauty pageants. The winners' body size or weight becomes the standard for these adolescents and young Nigerian women. Onyejiaku and Onyejiaku report that Nigerian adolescents and young women spend several hours before a mirror every day on body examination.⁷⁹⁰ The purpose for this examination is usually to detect any unusual feature that would not add to their beauty. Consistent body examination however does not portray body dissatisfaction or disturbance. The respondents in this study show body satisfaction by stating that they would not change their current thin body in the future, that they do not regret assuming the thin body,

⁷⁹⁰ Onyejiaku and Onyejiaku, *op. cit.*

nor do they feel the urge to cover parts of their body to avoid embarrassment. These are signs of contentment and satisfaction with the thin body created through self-starvation. Moreover, the confirmation that they would not change their thin body to the normalised body affirms their body contentment. This confirms that they are conscious of their actions and therefore aware of the limit of their food restriction or weight control measures. May be they are conscious of the medical implications of exceeding certain limits. That suggests they would not go below the cut-off line or point for body weight of less than 85 percent of what is normal for the person's age and height.⁷⁹¹ It should be observed that even though majority of the respondents would not like to change their anorexic body to a normalised one in future (57.9%), many of them (42.1%) would do so. This also tends to confirm that they are conscious of their actions. The finding that the respondents do not feel any physical weaknesses as a result of being extremely thin (80.3%) again shows they are comfortable with the anorexic body and do not show the medical diagnostic consequences of self-starvation. It is known that people who assume this extremely thin body are likely to suffer from anorexia nervosa, which leads to some discomfort. These include obsessive fear of becoming fat, suspension of menstrual periods and unrealistic body image.⁷⁹²

Body dissatisfaction is a key feature of the anorexic body in western culture. The way the individual identifies or interacts with the body is important; however, in many ways consideration is also given to the way the body is perceived by the outside world. Contrary to the western cultures where the family usually reports the individual for treatment and involuntary commitment, the analysis of women in

⁷⁹¹ Alloy, *et al*, *op. cit.*

⁷⁹² *Ibid.*

Calabar reveals a different outcome. 78.5% of individuals noted that they have not been advised by family or friends to seek medical treatment and would not consider treatment even if recommended. 62% was clear that they would not influence their friends to assume the anorexic body even if it is within meaning. The meaning centred anorexic body ideal is established on the bases of individualised experiences and autonomous choices therefore directly influencing another individual to assume the anorexic body defeats the principle. Interestingly, results also show that an overwhelming 80.3% do not experience any side effects of anorexia as evidenced in western society. Medical diagnostic of physical characterisation of the anorexic body include: weakness, fragility, tiredness and inability to lead a normal life. The women analysed in Calabar proved completely similar and showed no evidence of frailty or inability to fulfil their normal obligations.

5.3.3 Table 4

The findings showed that majority of the respondents assume the anorexic body to take control of their body (82.3%); resist cultural oppressive regime (57.8%); express freedom (autonomy) over their body (73.9%); refute mental illness theory (88.1%); guide against previous experience of a non-thin body (61.4%); Nigerian environment support for freedom to control one's body without stigma of mental illness (69.5%); resist the cultural ideal (regarding the plump body as a sign of beauty) (61.8%); not for the attraction of the opposite sex (60.8%); not for physiological and medical grounds (66.3%); show that anorexic body is not mental illness (72%). That majority of the respondents assume the anorexic body to take control of their body (82.3%) suggests that some adolescents and young women are advised on the acceptable body

weight in their culture often imposed by cultural ideals prevalent in their communities. Traditionally, the African woman is defined as being beautiful when fat or curvy. It is customary in most African culture for a maiden or young girl to uphold the ideal plump body so that she can be attractive, and acceptable and presentable for marriage. The notion of thinness in Africa even in contemporary times is affected by these African understanding of a beautiful body and the traditional African perception of a beautiful woman. This may be the reason why anorexia nervosa manifestation is less pronounced in Nigeria.

Marriage in these communities signifies attaining womanhood and is accepted as a core aspect of the culture and tradition. Nigerian mothers would therefore desire their daughters to marry as early as possible, especially among the lower socio-economic class. The fat or fleshy woman will therefore be more appealing to the suitors rather than the thin woman. It is therefore understandable why 82.3% of the young women analysed would elect to take control of their body through self-starvation as an act of resistance. That majority of the respondents assume the anorexic body to resist cultural oppressive regime (87.8%) is partially explained by their desire to control their body. Nevertheless, in some cultural settings in Nigeria, especially among the lower socio-economic class, the cultural practice demands that a young girl attains certain body weight specifications before marriage. An example is the fattening room for some adolescents among the Efiks in Cross River State in Nigeria where young women are forced to remain in fattening room over a period.⁷⁹³ Under very controlling circumstances, these women are subjected to hourly consumption of food. Food here assumes the mantle of suppression and the body stripped of its strength.

⁷⁹³ BBC, *op. cit.*

The determination of women within these communities to control their body and resist cultural oppressive regime would be signified by food denial. Corrington asserts that food refusal signifies self-denial and a refusal to be dominated hence it is self-empowering, “a triumph of the will over bodily limitations, and the forging of a new identity”.⁷⁹⁴

As previously stated, there is no association between anorexia (extreme thinness) and mental illness in Nigeria. The analysis of the empirical data from Calabar confirms this theory. Interestingly, the sampled women do not associate anorexia nervosa with any other eating disorder related illness. The study in Calabar revealed that 88% of females refute the mental illness theory established in western medical discourse; this is unsurprising, as extreme thinness through self-starvation is not recognised as a mental illness. Although these women fulfil the criteria of anorexia in weight and size (BMI), other prevalent diagnostic indications of mental illness are also absent. The decisions to self-starve is also made voluntarily and consciously and there has been no record of death due to self-starvation as a resistance. Exerting self-control transcends bodily appetite but also extends to sexual restraints and reproductive rights. Controlling their body through self-starvation is a method of liberation and discipline enabling individualised resistance of the “prevailing values of societies which they do not control”.⁷⁹⁵ The desirability of the woman to the male gender is part of the culturally acceptable reason to uphold the fat beauty standard in Calabar. One would have expected women in these communities would assume the ideal standard of beauty to attract the opposite sex; however the outcome reveals that 61.8 percent reject the cultural ideal standard of beauty whereas 60.8 percent do not want to be the

⁷⁹⁴ Gail Corrington, ‘Anorexia, Asceticism and Autonomy: Self Control as Liberation and Transcendence’ (1986) 2(2) *Journal of Feminist Studies in Religion* pp. 60-61.

⁷⁹⁵ *Ibid.*

subject of male admiration. Invariably, assuming the anorexic body is a resistance to masculine dominance in determining the ideal beauty for the females. They believe the female body is objectified, implying desirability, thus her value is being a suitable pick for wife, vessel of reproduction and catering to the needs of the man.

76% of the participants affirmed that they have not been subjected to any form of involuntary treatment for their thin body. 24.6 percent of the participants who recorded involuntary treatment were most likely treated without formal legal orders compelling them to undertake treatment against their wish. Tan et al have however noted that there are other ways to achieve compulsion, which might exclude legal means.⁷⁹⁶ In the absence a formal enforcement mechanism, involuntary treatment can also be achieved by compelling the individual to accept voluntary treatment without the clinical use of legal powers. Although there no data to suggest a record of death or chronic illness from self-starvation in Nigeria, general justification to implementing involuntary treatment is to preserve life. That majority of the respondents (61.4%) said they assume anorexic body to guide against previous experience of a non-thin body reveal that their lived experience was not favourable. Aside from societal cultural imposition, there is also the negative stigmatization of fat individuals as it could be that these respondents might have been fat before, or observed the plight of such people in the society. Fat or obese people often encounter many negative attitudes in Nigeria and other parts of the world as lazy, weak and unproductive. They are seen as lazy, weak and sickly in Nigeria. Lack of body satisfaction prior to assuming the anorexic body could also be because of the lack of control they experienced whilst preserving their body in line with the womanhood ideals of their

⁷⁹⁶ Jacinta O.A. Tan , Anne Stewart, Raymond Fitzpatrick, R. and Tony Hope, 'Attitudes of Patients with Anorexia Nervosa to Compulsory Treatment and Coercion' (2010). 33(1) International Journal of Law and Psychiatry pp.13-16.

culture. Although the ideal beauty is the curvy woman, prolonged overindulgence on food leads to binge eating disorder and obesity.

That the Nigerian environment supports freedom for one to control her body without stigma of mental illness (69.5%) and freedom to express autonomous right without stereotype of mental illness (67%) suggest the legal and cultural differences between Nigeria and some other societies. Given that the Nigeria environment does not consider abnormal eating pattern as a mental illness should definitely motivate women to voluntarily assume the anorexic body, in view of the fact that self-starvation and excessive exercise are a measure taken by the anorexic person to become very or extremely thin. Nigerians in particular do not appear to fit into the typical profile of western bound anorexic bodies. Typically, those who try to maintain thin bodies through self-starvation intend to fulfil a role not imposed by patriarchal demands. There is no reflection of fear of weight gain or fat phobia rather there is conscious engagement with their bodies within meaning and reasoning. The idea of body perfection does not form part of their journey, rather control and autonomous actions that fulfil bodily integrity resonates within the individual's journey, which includes past and present experiences.

Given that anorexia is not a mental illness in Nigeria's mental health laws, it is very easy for clinicians to argue that anorexia is non-existent in Nigeria but mostly a western culture bound syndrome. However, modern anorexia is becoming more diversified in features and within socio-cultural and political discourses which lend more meaning to its multifactorial nature. The definition of anorexia around the globe is dependent on one crucial criterion: the BMI must be below 17.5. Once this criterion

is fulfilled, the individual is considered anorexic; however, western pattern adds a more conflicting narrative which includes fear of weight gain and body distortion. This fat phobia criterion is definitely a western bound feature as they have not been found to be a factor constituting anorexia in non-western culture. The most credible way to identify anorexia within non-western culture is to go with communities where the ideal standards of beauty are parallel to western beauty, where media influence is non-existent and fat phobia is not a factor to justify beauty ideals. Calabar in Nigeria fulfils all criteria because of its ancient tradition of the fatter, the more appealing to the society. Women sampled who have a BMI of 17.5 and below voluntarily embark on self-starvation. It is uncommon to encounter an adverse health issues associated with their eating patterns and their behaviour pattern is normalised as they are functioning members of the society. Their anorexia is meaningful and productive in establishing boundaries of consent, choice and autonomy. Anorexia is centred on self-image, identity and the ability to function autonomously without any control or coercion. Accommodating the expectations of culture would fulfil the woman's expected traditional roles thereby denying them control over the way their body changes and develops.⁷⁹⁷ Traditional (bio-medical) explanations of anorexia might be applicable here as the body here is analysed in a way that projects self-liberation as a worthy cause regardless of the entrapments of future lack of fulfilment should the symbol of power and control be removed. The outcome of the studies presented a cultural explanation that clarified the values, which these women associate with anorexia nervosa. Self-denial here transcends mere ascetic purpose and individual identities are created to avoid the traditional roles, which a particular body shape

⁷⁹⁷ Corrington, *op. cit.*, p.53.

signifies.⁷⁹⁸ When the needs of autonomy are unsatisfied, the individual harbours the “feelings of ineffectiveness and fears of losing control”.⁷⁹⁹ Understandably, these women are immersed within a culture where women are considered subservient to men hence the need to be independent and self-defined.⁸⁰⁰ Response to curtailment of their liberty would attract resistance.⁸⁰¹ Corrington therefore notes that “eating and non-eating thus becomes a symbol of power and control; a refusal to eat is a refusal of any authority over the body other than one’s own”.⁸⁰²

5.4 Conclusive Findings

From the findings of the study, the following conclusions are drawn;

1. Meaning-centred anorexia exists in non-western cultures.
2. The factors underlying self-starvation in non-western cultures do not include fear of weight gain and body distortion.
3. There is no relationship between self-starvation and mental illness. The same applies to excessive exercise and mental illness. Invariably, self-starvation and excessive exercise to become thin may not lead to mental illness.
4. Self-starvation and food refusal are regarded as means to exercise freedom of choice within a patriarchal society.
5. Individualised autonomy is applicable in the absence of coercive mental health laws imposing involuntary treatment for the purposes of restoring weight gain.

⁷⁹⁸ *Ibid.*, p.52.

⁷⁹⁹ Franzisca V. Foreich, , Lenny R. Vartanian, Matthew J. Zawadzki, Jessica R. Grisham and Stephen W. Touyz, ‘Psychological Need Satisfaction, Control and Disordered Eating’ (2017) 56(1) British Journal of Clinical Psychology pp.53-64.

⁸⁰⁰ Corrington, *op. cit.*, pp.52-53.

⁸⁰¹ *Ibid.*

⁸⁰² *Ibid.*

6. Multiple culture bound meanings were attributed to the reasoning underlying the assumption of the meaning-centred anorexic body. They include, freedom to control their body; resisting cultural oppressive regime and expression of autonomy.
7. Self-starvation and extreme thinness are not ordinarily linked to mental illness except when reinforced by the law
8. The universal stereotype that extreme thin body signifies mental illness is devalued in non-western cultures.

CHAPTER SIX

Involuntary Interventions

6.

The previous chapter showed that the meaning centred anorexia body can be voluntarily and consciously achieved through self-starvation. Hence, a meaning centred variation to this experience can be established. The purpose of this chapter is to examine the implication of treatment refusal and will address the role of the Mental Capacity Act 2005 in establishing the capacity or incapacity of the individual to consent to treatment. First in determination of what represents the best interest this chapter considers the implementation of the values and choices of the anorexic body during decision-making. The second part of this chapter critically examines the legal and ethical implications of involuntary treatment and the impact on individualised freedoms of expression and autonomy.

6.1 Mental Capacity Act 2005

The best interest principle test derives from the doctrine of necessity by the House of Lord in 1989.⁸⁰³ The codified best interest test applicable today does not consider the direct participation of the wishes of persons who lack capacity.⁸⁰⁴ The Mental Capacity Act 2005 provides the legal framework for determining the best interests for persons adjudged to lack capacity to make treatment decisions. The concept of best

⁸⁰³ Emily Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions about their Medical Treatment' (2018) 81(2) Medical Law Review pp.247-248.

⁸⁰⁴ *Ibid.*

interest was enhanced to safeguard the interests of people who do not have the capacity to make decisions regarding their medical treatment or social care. Section 4 (6) (a) provides that in determining best interest careful consideration should be firstly accorded to the patient's feelings and wishes, which includes written statement during periods of established capacity.⁸⁰⁵ In addition, "the beliefs and values that would be likely to influence his decision if he had capacity and the other factors that would be likely to consider if he were able to do so".⁸⁰⁶ Theoretically, the MCA 2005 presents a structure to ensure that decisions made in the best interest of disordered persons must be efficiently implemented in a way that is less constricting on the person's rights, liberty, autonomy and self-determination. The principle of best interest is very central in the way persons adjudged to have mental disorder are treated and managed. Section 4(3) of the MCA 2005 provides that in determining the best interest of a patient, consideration must be given to the likelihood of the person regaining capacity regarding the issues in question and if there is a probability, then the chances are that capacity would be regained.⁸⁰⁷ In retrospect, medical treatments carried out on behalf of these patients should not be "restrictive of the person's rights and freedom of action".⁸⁰⁸ Section 4(1) of the MCA 2005 disallows any person from depriving others of their liberty except authorized by schedule A1 (deprivation of liberty in a hospital setting).⁸⁰⁹ Section 4B (1-5) however points out that the deprivation of liberty may be a vital act necessary for giving patients life sustaining treatment.⁸¹⁰

⁸⁰⁵ Mental Capacity Act 2005 s.6 (a).

⁸⁰⁶ Mental Capacity Act 2005 s.6 (b-c).

⁸⁰⁷ Mental Capacity Act 2005 s 4 (3).

⁸⁰⁸ *Ibid.*

⁸⁰⁹ Mental Capacity Act 2005 s 4 (1).

⁸¹⁰ Mental Capacity Act 2005 s 4 (B)(1-5).

The provisions of MCA 2005 also engage with the implications of consent and advanced decision making in cases involving the treatment of persons who lack the capacity to consent under the act. Once incapacity has been recorded by the clinicians, other underlining factors are not explored further to establish a better relationship between the person and the courts. It then becomes the duty of the courts after evaluating the facts of the case to determine whether and to what extent a person's capacity to consent has been compromised by their mental illness. When a person is adjudged to lack the capacity to consent to being force-fed, then the decision on what is in her best interest will arise. Ordinarily, the courts are more concerned with circumstances in which it might be lawful to withhold from a patient's medical treatment or care by what means of which his or her life may be prolonged. One of the founding principles of medical law is that consent must be given prior to treating any competent adult. The sole aim of consent under medical law is not to act as a defense in itself but as a vital component in administering medical treatment.⁸¹¹ Maclean notes that medical treatment cannot be legitimized unless consent is voluntarily given,⁸¹² however in practice adult persons established to be incompetent can be treated without obtaining the prerequisite consent under the MCA 2005.⁸¹³ For consent to be given by the anorexic body, the individuals must first possess the capacity to consent; the individuals must also offer her consent voluntarily and must have a great understanding of the medical treatment for which they intend to consent to.⁸¹⁴ Consent under the MCA 2005 can be applied in a legal, moral and clinical capacity.⁸¹⁵ Jackson asserts that legally unlawful practices can become lawful once

⁸¹¹ *Airedale NHS Trust v Bland* [1994] 1 AC 212.

⁸¹² Maclean, *op. cit.*, pp .45.

⁸¹³ *Ibid.*

⁸¹⁴ *Ibid.*

⁸¹⁵ Emily Jackson, *Medical Law: Text, Cases and Materials* (New York, Oxford University Press 2010) pp. 217.

consent is obtained. As a moral obligation, obtaining consent ensures the respect for the right to self-determination and clinically “a patient will make it easier to treat her, her cooperation may contribute towards the treatment success”.⁸¹⁶

Overtime, the MCA 2005 established a structure for considering the capacity of a person to participate in his or her own decision-making. Section 3 of the MCA 2005 provides a guideline to assess the decision-making capacity of an individual. Section 3 (1) of the MCA 2005 states that an individual is unable to make decisions for themselves when they are unable to show understanding, retain or “use or weigh that information as part of decision, or to communicate his decision (whether by talking, using sign language or any other means)”.⁸¹⁷ In *Re T (Adult Refusal of Medical Treatment)*, Lord Donaldson affirmed that: “the right to decide one’s own fate presupposes a capacity to do so. Every adult is presumed to have that capacity but it is presumption that can be rebutted.”⁸¹⁸ The MCA 2005 however presumes that all people have the capacity to make their own treatment decisions except incapacity is otherwise established.⁸¹⁹ Incapacity can therefore be established if at the time of decision-making the person is unable to make decisions for themselves because of an existing impairment of the mind or brains or a disorder in the way the mind or brain functions notwithstanding the temporal or permanent nature of the disorder.⁸²⁰ Implementing the provisions of the MCA 2005 ensures that individuals lacking the

⁸¹⁶ *Ibid.*

⁸¹⁷ Legislation.gov.uk, ‘Mental Capacity Act 2005’ available at <http://www.legislation.gov.uk/ukpga/2005/9/section/25> [accessed 17th February 2018] s. 3(1).

⁸¹⁸ *Re T (Adult Refusal of Medical Treatment)* [1992] 3 WLR 782.

⁸¹⁹ Mental Capacity Act 2005 s 2 (1),

⁸²⁰ Mental Capacity Act 2005 s 2(2-3).

prerequisite capacity to make their own decision are safeguarded during the process of implementing decisions on their behalf.⁸²¹

S.3.14 (1) of the 1995 Mental Incapacity Law Commission report identifies incapacity as present when the person suffering from any form of disorder of the mind and brain results to an impairment in their ability to understand a decision made on their behalf or reason rationally so as to make a balanced decision based on the information provided to them.⁸²² S.3.14(2) notes that incapacity can also be shown when the person is “unable to communicate a decision on that matter because he or she is unconscious or for any other reason”.⁸²³ To establish an inability for a person to make critical decisions, section 3 (a-d) of the MCA 2005 stipulates that it must be established that the person is unable to evaluate, utilize, comprehend, recall or remember the necessary information required during decision making. The patient must also be able to efficiently convey his decisions through speech, sign language or through any other medium.⁸²⁴ A patient cannot also be treated as having incompetence except all these necessary steps have been fulfilled without any progress or success.⁸²⁵ Section 24-25 of the MCA 2005⁸²⁶ lays down the general principles, validity and applicability for accessing an advance decision. The assessment should always begin and include respect for the person’s autonomy and over all wishes.

⁸²¹ Mind for Better Mental Health, Mental Capacity Act 2005 available at <http://www.mind.org.uk/information-support/legal-rights/mental-capacity-act-2005/#7> [accessed 18th February 2019].

⁸²² The Law Commission, ‘Mental Incapacity’ (1995) available at <https://www.mind.org.uk/media/17625468/mca-2005-2017.pdf> [accessed 5th May 2019] p.36.

⁸²³ *Ibid.*, p.36.

⁸²⁴ Mental Capacity Act 2005 s 3(1) (a-d).

⁸²⁵ Mental Capacity Act 2005 s 1(3).

⁸²⁶ Mental Capacity Act 2005 s24-25.

The provisions of the MCA 2005 reveal emerging outlines in the way the principles of autonomous rights are viewed in line with current mental health of the person. Although the emerging status of the disordered individual under the MCA 2005 presents a structural balance in treatment enforcement however the medical motive in applying the capacity test is subjected to a new lens of debate. Section 1 of the MCA 2005 captures its purpose or relevance. The MCA 2005 protects people who lack the capacity. Theoretically, individuals who lack capacity are to be allowed to participate in decision making which affect them. Clinicians are therefore directed to provide the enabling environment to offer the needed protection by ensuring achievable goals are met.⁸²⁷ For the purposes of fulfilling the MCA 2005, section 1(2) of act removes the stereotypical presumptions of incapacity except otherwise established. Invariably, in acknowledging the assumed capacity of all persons,⁸²⁸ the individual is therefore within their right to make decisions regarding their treatment.⁸²⁹ Realistic steps must therefore be implemented to ensure that they are not regarded as lacking the ability to fulfill their obligation.⁸³⁰ A bad or irresponsible decision does not equate incapacity and therefore cannot be treated as lacking the capacity to make decision.⁸³¹ Third party decision on behalf of a person adjudged to lack capacity must then be within their best interest.⁸³² In all situations, unconsented treatment procedures must therefore be made “in a way that is less restrictive of the person’s rights and freedom of action”.⁸³³ The intention of the MCA 2005 is to offer some level of protection for individuals who lack capacity, however the challenge is not in the theoretical

⁸²⁷ Legislation.gov.uk., Mental Capacity Act 2005 available at <http://www.legislation.gov.uk/ukpga/2005/9/section/1> [accessed 10th February 2018].

⁸²⁸ *Ibid.*

⁸²⁹ Mental Capacity Act 2005, Section 1(3).

⁸³⁰ *Ibid.*

⁸³¹ Mental Capacity Act 2005, Section 1(4).

⁸³² *Ibid.* Section 1(5).

⁸³³ Mental Capacity Act 2005, Section 1(6).

understanding but practical implication especially within the framework that accommodates the provisions of the Mental Health Act 1983. The Mental Health Act 1983 already established that individuals adjudged to lack capacity have no competence or ability to participate in their own decision-making. Whereas on the other hand, the MCA 2005 recognises capacity and provides an assessment to actualizing those autonomous goals regardless of the adjudged incapacity. There is therefore a dissension in the trajectories of implementing both frameworks.

The approach of the English courts in assessing the capacity or incapacity of a person suffering from anorexia to make treatment decisions is not simple or straightforward. Mental capacity cases involving the anorexic person are difficult because of the complexity that arises in assessing what is in their best interest on one end and their capacity or incapacity to make a balanced decision that reflects their best interest on the other. The diagnosis of anorexia nervosa, which is a form of mental illness automatically, places assessment for treatment of this illness in the hands of a third party (usually a treatment practitioner or the courts for the purposes of enforcing clinical decision). Invariably these third parties may only enforce treatments deemed to be in the patient's best interests, which may or may not include the values, wishes and expectations of the patient. Moreover, in cases where the patient withholds their consent to receive any form of treatment stipulated by treatment professional, the patient is viewed as lacking the mental capacity to make the decision *ab initio*. At the critical stages of their physical deterioration, patient's denial of the illness, or ambivalence regarding the severity of the eating disorder, is frequently taken as a demonstration of a lack of capacity required in giving valid consent. This automatically strips them of their rights to participate in

treatment decisions and diminishes their chances of having their wishes put in consideration during capacity assessments. John Coggon points out that the provisions of the MCA 2005, the common law and other substitutes aim to include the standards and morals of the patient in decision making on their capacity⁸³⁴ however in the event this rule is disregarded as in the case of *A Local Authority v E*, the courts has to furnish a balanced reason for exercising their discretion in this manner.⁸³⁵

In *A Local Authority v E*, a 32-year old intelligent woman grew up in an exceptionally happy and loving home with parents and siblings who cared about her and protected her welfare.⁸³⁶ However, at the tender ages of eleven and fourteen, E experienced sexual abuse which triggered her to start a pattern of eating little, inducing herself to vomit after a meal and alcohol abuse.⁸³⁷ This resulted to serious health complications and the danger of sudden death having refused to eat or drink large quantity of water. The issues for determination before the court were not to establish if *E* lacked mental capacity prior to the hearing of the case but *E*'s capacity at the instant the case was presented to the court.⁸³⁸ There is an underlying implication that the anorexic will give their informed consent to treatment or accept treatment wholeheartedly. If informed consent to start re-feeding willingly is given, self-starvation would not have been resorted to in the first instance and hence there would be no need for the intervention of the law.⁸³⁹ Another dimension presented by the clinicians involved *E*'s capacity to make advanced decision to reject any

⁸³⁴ John Coggon, 'Anorexia Nervosa, Best Interests, and the Patient's Human Right to "a Wholesale Overwhelming of her Autonomy": *A Local Authority v E* [2012] EWHC 1639 (COP) [2012] HRLR 29' (2014) 22(1) Medical Law Review pp.119-124.

⁸³⁵ *A Local Authority v E* [2012] EWHC 1639 (COP).

⁸³⁶ *Ibid.*

⁸³⁷ *Ibid.*

⁸³⁸ *Ibid.*

⁸³⁹ *Ibid.*

treatment intended to preserve life. Advanced decisions are usually made when a person possesses the capacity to make those decisions. The circumstances under consideration at that point during the advanced *decision* making are usually specific and are intended to be extended to the periods of their incapacity. However, S.24 (b) states that treatment should be discontinued once the person “lacks capacity to consent to the carrying out of the treatment”.⁸⁴⁰

To obtain consent, the MCA 2005 provides that consideration must also be given to the persons “past and present wishes and feelings”, “beliefs and values” and other external factors such as advanced decisions and written statements.⁸⁴¹ Advanced decisions enable people with capacity who anticipate any form of incapacitation in the future to make decisions refusing involuntary intervention.⁸⁴² Section 24 provides that an advanced decision is applicable when it is made by a person who is 18 years and above when he “has capacity to do so”. Thus advanced decisions may affect future “specified” treatments proposed to be carried out or continued by a person providing health care for him. Advanced decisions can also be “withdrawn or changed” so far the person still has the capacity to do so.⁸⁴³ An advanced decision has to also be valid and “applicable” to the treatment in question and such decision cannot be withdrawn the time he had the capacity to do so.⁸⁴⁴ For an advanced decision to be valid, it must be signed by the patient and witnessed by another person in his presence. The witness must also sign and acknowledge his signature in the presence of the patient.⁸⁴⁵ An advanced decision is therefore not applicable during life sustaining treatments unless the patient can reiterate that the

⁸⁴⁰ Mental Capacity Act 2005, S. 24(b).

⁸⁴¹ Mental Capacity Act 2005 s 4(3)(6).

⁸⁴² Whiteman, *op. cit.*

⁸⁴³ Mental Capacity Act 2005 s 2(4) (a)(b).

⁸⁴⁴ Mental Capacity Act 2005 s 25 (1)(2).

⁸⁴⁵ Mental Capacity Act 2005 s 6 (a)(d).

treatment in their advanced decision must be applied even if they are in danger of losing their life.⁸⁴⁶ A person who believes and is contented that an advance decision exists and is valid and therefore withdraws or discontinues treatment of a patient as written in their advanced decision would not be held liable.⁸⁴⁷ It is however at the discretion of the court to make a declaration on the validity, existence and applicability of an advanced treatment decision.⁸⁴⁸

The advanced decision must have been made when the individual was adjudged to have the mental capacity however if those advanced decision to refuse treatment is made within periods of incapacity, then enforcing unconsented feeding would be within their best interest. The implementation of a person's advanced decision is very potent in addressing and ascertaining the mental capacity of the individual. Advanced decisions reflect the conscious wishes, values, morals and choices of the individual, which ought to be enforceable at the time they lack capacity to continue to make those decisions. The decision of the court in *A Local Authority v E* to disregard *E*'s advanced decision and direct for continual force-feeding has raised ethical questions.⁸⁴⁹ *E*'s advanced decision declining resuscitation or administering any more therapy to preserve life was a subject of deliberation, *E* having been admitted under the Mental Health Act, was continuously force-fed and subjected to unbearable pain. Although the medical team established that the advanced decision of *E* was made within the periods she possessed capacity.⁸⁵⁰

The judge decided that *E* lacked the capacity to make the July 2011 advanced decision evidenced by *E*'s conscious attempt to place herself in a position that made

⁸⁴⁶ Mental Capacity Act 2005 s 5.

⁸⁴⁷ Mental Capacity Act 2005 s 6 (2).

⁸⁴⁸ Mental Capacity Act 2005 s 26 (4) (a) (b)(c).

⁸⁴⁹ *A Local Authority v E* [2012] EWHC 1639 (COP).

⁸⁵⁰ *Ibid.*

such decision valid.⁸⁵¹ Although the judge accepted that the October 2011 written directive was legally valid however the subsequent detention of E under the Mental Health Act on the same day as the directive was made throws a balance of uncertainty on her capability to have made such advanced decision. In rejecting the enforceability of E's advanced decision, Mr Justice Jackson stated:

“In the light of prior conclusion that E did not have capacity to make the October advance decision, it is unnecessary to decide whether she has done something clearly inconsistent with remaining fixed decision. E's actual behaviour in refusing food has been entirely inconsistent with her decision and I would have been reluctant to conclude that her decision was undermined by trusting statements about what are bound to be deeply mixed feelings.”⁸⁵²

The judge questioned this decision on the grounds that although *E* showed competency at the time the advanced decision was made however *E*'s behavior afterwards showed inconsistency and therefore incompatible with section 25(2) of the MCA 2005.⁸⁵³ In reality if the advanced decision of the individual, which contains their conscious wishes, values and choices, cannot be upheld, then finding a balance that can protect the autonomous decision of the individual is crucial for advancing rights. The denial of *E*'s rights to refuse further medical treatment as evidenced in her advanced decision reflects the courts dual failure to guarantee

⁸⁵¹ [2012] EWHC 1639 (COP) WL, paras, 58-59.

⁸⁵² *Ibid.*, para 69.

⁸⁵³ *Ibid.*

autonomous actions and individual freedom at the point of capacity and incapacity. Coggon notes that the case of *E* reveals the lack of clarity and concrete directive from the courts on how decisions of incapacity are reached.⁸⁵⁴ It is critical that in denying a persons advanced decision made within the periods of their capacity that there is “clear and rational basis” for how decisions of incapacity and capacity are reached.⁸⁵⁵ The focus often ends with a debate if autonomy should supersede welfare in the sense that in the fulfilment of their autonomous rights, one has to forgo the right to safeguard her life even with the decision arrived at. Notwithstanding, it is evident that the finding of incapacities relating to anorexia nervosa has become “inexplicable, incoherent or inconsistent”.⁸⁵⁶ If the anorexic body is deemed vulnerable, the potential for exploiting their vulnerability by the public institutions are very high.⁸⁵⁷ A good and balanced judgment will reflect flexibility by ensuring core participation, show a meaning centered thinking in analyzing actions and understanding the values and morals underlying every decision.

Sokol points out that capacity and best interests are “slippery concepts” and remains undefined.⁸⁵⁸ The balance between establishing best interests of *E* in this instant was weighed on the intuition or intuitive thinking of the judge.⁸⁵⁹ Reference to intuition may simply allude to the open ending nature of defining what actually constitutes best interests and in the case of *E*, it was balanced on the judge’s views at the

⁸⁵⁴ Coggon, *op. cit.* pp.119-130.

⁸⁵⁵ *Ibid.*

⁸⁵⁶ *Ibid.*

⁸⁵⁷ *Ibid.*

⁸⁵⁸ Daniel Sokol, ‘As Hard as it Gets: The case of Anorexic *E* and the Right to Die’ (2012) available at <https://www.theguardian.com/law/2012/jun/19/anorexia-e-right-to-die> [accessed 12th August 2018].

⁸⁵⁹ *Ibid.*

time.⁸⁶⁰ For a person who made their conscious decision to refuse treatment that advanced decision reflects their best interest in many ways. Regardless of the capacity E has shown by having the ability to retain and process information at the time of making the advanced decision, it appears that paternalistic intervention to preserve life will always precede autonomous choices. Emphatically E did not make a choice to die or ask to exercise her right to die, rather *E* sought to implement her right to refuse the involuntary force-feeding which was causing her unbearable pain. The right to die represents seeking euthanasia through means of voluntary or assisted death whereas the right to refuse involuntary medical treatment tilts the balance of decision making towards respecting the values and autonomous choices of the individual regardless of the final outcome. Sokol notes that scale of determination of best interest falls in the route of enforcing palliative, however “the violence, duration and trauma of force feeding, the grim prognosis, and E’s clearly articulated wishes (even without legal capacity) trump, in my view, the preservation of life and other factors in the list.”⁸⁶¹

The accumulated reasoning for *E*’s self-starvation was embedded in her childhood experiences of sexual violence. The necessity to resort to food restriction cannot be validly ascribed to the presence of a mental disorder. Invariably, resorting to self-starvation was evidenced after a traumatic experience. In an attempt to separate the mental disorder evidenced by self-starvation, it will also mean that clinicians have to evidence that sexual violence resulted in *E*’s development of anorexia. The experience in itself shaped *E*’s values, and choices in regaining the control of her body in a way that is inconsistent with the medical acceptance. For a meaningful

⁸⁶⁰ *Ibid.*

⁸⁶¹ *Ibid.*

disease to occur, there must be causative action guided by an experience that necessities the reasoning behind self-starvation and the reactive outcome of the physically anorexic body. Ideally assessing the mental capacity or incapacity of the anorexic body should include or reflect their ideals, values, choices, wishes, morals and expectations however to fulfill or incorporate such ideals during capacity assessment or critical treatment decision-making is very problematic from clinicians and the court. This is because the diagnosis of anorexia nervosa is already presented within the label of severe mental disorder and therefore places assessment for treatment of this illness in the hands of a third party (usually a treatment practitioner or the courts for the purposes of enforcing clinical decision). Invariably these third parties may only enforce treatment deemed to be in the patient's best interests, which may or may not include the values, wishes and expectations of the patient. Moreover, in cases where the patient withholds their consent to receive any form of treatment stipulated by treatment professional, the patient is invariably viewed as lacking the mental capacity to make the decision *ab initio*. At the critical stages of this illness, patient's denial of the illness, or ambivalence regarding the severity of the eating disorder, is frequently taken as a demonstration of lack of capacity required for valid consent.⁸⁶² This automatically strips them of their rights to participate in treatment decisions and diminishes their chances of having their wishes put in consideration during capacity assessments. Coggon points out that if the provisions of the MCA 2005, the common law and other substitutes all aim to include the standards and morals of the patient in decision making on their capacity. In the event this rule is

disregarded as in the case of *A Local Authority v E*, the courts have to furnish a balanced reason for exercising their discretion in this manner.⁸⁶³

In answering the question of whether E at the time of judgement had the mental capacity to make such decision, Mr Justice Jackson Peter noted that E could fully communicate, understand, process information and retain as stipulated under section 3(1) of the Mental Capacity Act.⁸⁶⁴ However, E's eating disorder has left her brain impaired and unable to make the appropriate decision for herself as her fear of weight gain supersedes her better judgement. Against this background, Mr Justice Jackson Peter made the decision that E lacked the capacity under sections 2 and 3 of the MCA 2005 to make life sustaining decision in her current state⁸⁶⁵ However, the exact criteria for assessing E's mental capacity seemed to be based on the mental disorder classification rather than if she was capable of assuming those roles. Declaring E as lacking capacity to make treatment decision seemed to doubt her beliefs and undermine her values. Glover-Thomas tentatively viewed anyone suffering from anorexia nervosa as having no capacity therefore unable to make those decisions. E's parents questioned Glover-Thomas's conclusion stating that:

“It seems strange to us that only people who don't seem to have a right to die when there is no longer appropriate treatment available are those with an eating disorder. This is based on the assumption that they can never have capacity around any issues connected to food. There is a logic to this, but not from the

⁸⁶³ Coggon, *op. cit.* p.2.

⁸⁶⁴ *A Local Authority v E* [2012] EWHC 1639 (COP).

⁸⁶⁵ *Ibid.*, para, 51.

perspective of a sufferer who is not extended the same rights as any other person”.⁸⁶⁶

Glover-Thomas points out that administering medical treatment is only unlawful and may be classified as a crime of battery if the individual has the capacity or is adjudged as being conscious and having sound mind”.⁸⁶⁷ With anorexia classified as a mental disorder, for the purposes of administering the MCA 2005, the anorexic body is classed as disabled. The Equality Act 2010 identifies a person with disability as having “a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on P’s ability to carry out normal day-to-day activities”.⁸⁶⁸ It has been long established that the standard anorexic body is able to carry out her daily functions and presents no intention to die. Glover-Thomas explains that the freedom to make autonomous decisions regarding our bodies and the right to bodily integrity is accepted in all democratic societies. A presumption exists that all adults of sound mind may accept and reject medical treatment irrespective of the foreseeable consequences. The law however is not absolute in this instance as the courts have the discretion to make a decision based on factual information from third parties who offer a different viewpoint from the patient’s. Hence, once the individual is considered to lack the required mental capacity to make a balanced physical treatment choice, such right of decision-making can be withdrawn from the individual⁸⁶⁹ by relying on the evidence brought by E’s parents, consultant psychiatrists, medical, social workers and legal professionals.

⁸⁶⁶ *Ibid.*, para, 52.

⁸⁶⁷ Nicola Glover-Thomas, ‘Treating the Vulnerable in England and Wales: The Impact of Law Reform and Changing Policy’ (2006) 29(1) *International Journal of Law and Psychiatry* pp.1-2.

⁸⁶⁸ Equality Act 2010. s6 1(a-b) available at <https://www.legislation.gov.uk/ukpga/2010/15/section/6> [accessed 5th December 2019]

⁸⁶⁹ *Ibid.*

Kong, et al note that the MCA 2005 is formulated with a “best interests model decision making”, it is yet to fully actualize the rights conferred on it.⁸⁷⁰ Failing to fully realize empowering ethos setting, there is continuous deliberations on applying capacity and best interest under the MCA 2005 especially concerning the level of participation or value that should be accorded to an individual in decision making.⁸⁷¹ However, Kong, et al interpreted the MCA 2005 within a value-based setting designed to empower persons who are the subject of proceedings.⁸⁷² Adapting the MCA 2005 with the intention of adding value will mean that the principles of autonomy are protected as the subjective wishes and feelings are taken into consideration during decision-making. The feelings and wishes of the individuals are however grounded by their experiences, whether meaningful interactions or traumatic endeavour. Each experience lends a contribution to the individualized goals, aspirations and choices that reflect their decisions. Clinicians and the courts evaluate person actions without identifying the underlining meanings behind their action. For instance, food refusal in itself is an action, values precede the actions but the meaning presents the motive to engage further and sustain the reaction or outcome in anorexic body were detention and force-feeding do not equal recovery or present a solution to self-starvation. Administering a meaning centred participation will enable clinicians protect the principles of autonomy by making the experiences that sustain the anorexic body’s action as part of fulfilling their values and wishes. Although in theory, the value-based approach seeks to ensure that the wishes and feeling of the persons are included in the decisions of best interests however in reality “the strict interpretation typically evokes a problematic separation between ascertaining a

⁸⁷⁰ Camilla Kong, John Coggon, Michael Dunn and Penny Cooper, ‘Judging Values and Participation in Mental Capacity Law’ (2009) 8(1) *Mdpi-Laws* pp. 1-22.

⁸⁷¹ *Ibid.*

⁸⁷² *Ibid.*

person's values (however conceptualized) from her actual participation, based on a literal interpretation of discrete and separable obligation".⁸⁷³ The inconsistency in the practical implementation of the MCA 2005 has prompted considerations on how best to ensure that the normative guidelines that appeal to the individual's best interest are adhered to. Kong et al suggested a value-based approach which interlinks with the objectives of the CRPD. According to Kong et al:

“The normative shift in the MCA and CRPD resides in the importance of protecting and promoting the decision-making autonomy of individuals with disabilities through the provision of necessary participatory mechanisms and supports that encourage their active involvement in deliberations regarding their care and treatment”.⁸⁷⁴

Invariably, with the emergence of the CRPD, attention is drawn to best pathway for the MCA 2005 to compliment the CRPD. Article 1 of the CRPD identifies disabled persons as having difficulty integrating fully into the society due to their long-standing “physical, mental, and intellectual or sensory impairment”.⁸⁷⁵ The preamble of the CRPD reaffirms the “need for persons with disabilities to be guaranteed their full enjoyment without discrimination”. Discrimination based on impairment therefore violates their “inherent dignity and worth”.⁸⁷⁶ Craigie asserts that the CRPD “forces a reconsideration of the principle of respect for a patients autonomy” by

⁸⁷³ *Ibid.*

⁸⁷⁴ *Ibid.*

⁸⁷⁵ Convention on the Rights of Person with Disability and Optional Protocol available at <https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf> [accessed 9th June 2019] pp. 1-2.

⁸⁷⁶ CRPD preambles h-n.

extending decision making capacity to mentally disabled persons who are subjected to third party decision makers and by highlighting the need for support by actualizing the patient's autonomy thereby confronting the conceptual interpretation of capacity.⁸⁷⁷ The CRPD recognizes the urgency in safeguarding and promoting human rights including "the importance for the persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices."⁸⁷⁸ Article 1 notes that the purpose of the CRPD is to ensure that the inherent dignity of the disabled are respected, guaranteeing that they have "full equal enjoyment of human rights and fundamental freedoms".⁸⁷⁹ Concerning the CRPD, the reoccurring deliberations regarding the influence of the MCA 2005 presents a narrative of the empowerment of disabled individuals.⁸⁸⁰ Decided cases post MCA 2005 has not particularly demonstrated a clear evolution of the judicial framework in enforcing treatment without engaging the wishes, values and decisions of the person.⁸⁸¹

In *NHS v L*,⁸⁸² Ms L was severely malnourished weighing a little over three stones at the time the declaration before the courts was pursued. L, a bright intelligent 29-years old, suffered from the most severe form of anorexia and was receiving treatment in an NHS Trust operated university hospital from March 2012. Despite being subjected to the best medical treatment by Anorexia Nervosa experts, Ms L's body weight continued to reduce drastically to as little as three stones. Given the severity of Ms L's malnourished state, treatment professionals were of the opinion that forcibly re-

⁸⁷⁷ Jillian Craigie, 'A Fine Balance: Reconsidering Patient Autonomy in Light of the UN Convention on the Rights of Persons with Disabilities' (2015) 29(6) Bioethics Journal p.398-408.

⁸⁷⁸ *Ibid.*

⁸⁷⁹ CRPD, Article 1.

⁸⁸⁰ Beverley Clough, 'Anorexia, Capacity and Best Interests: Developments in the Court of Protection since the Mental Capacity Act 2005' (2016) 24(3) Medical Law and Ethics p.434-445.

⁸⁸¹ *Ibid.*

⁸⁸² *NHS Trust v L*, 2012 EWHC 2741 (COP).

feeding L would have little or no impact in her recovery or preserving her life.⁸⁸³ There was also an indication that Ms L's life cannot be prolonged by artificial nutrition, which is a necessary form of treatment for these purposes. Therefore reversing Ms L's malnourished state by forcibly re-feeding her provides the only faint possibility of reversing her weight loss and preserving her life.⁸⁸⁴ The *NHS Trust* applied for a declaration at the court for protection regarding the mental capacity of L to engage in treatment decisions and that force-feeding was in her best interest. *NHS Trust* also raised the issue of the capacity of L to consent to involuntary treatment. The judge relying on the facts and evidence of Glover-Thomas concluded that L lacked the capacity to make any decision that relates to her nutrition, hydration and general medical treatment.⁸⁸⁵ Ms Justice King noted that in order to determine what is in the best interest of anorexic patient, such determination must be carried out in pursuance of section 4 of the MCA 2005. All the relevant circumstances surrounding the illness of the patient must also be taken into consideration.⁸⁸⁶ Ms Justice King ruled that it would be in the best interests of L to be provided with both medical treatment, nutrition and hydration which might include nasogastric tube feeding however such treatment should not be administered using physical force or without her consent. The judge also ruled that should L's illness deteriorate any further to the extent of it being terminal, protective steps should be followed to preserve her dignity whilst committing her to palliative care until at such time her life ends.⁸⁸⁷

The medical narrative in *NHS Trust v L* insists that once an impairment is established, enforced treatment is within the person's best interest, in order to save life or ensure

⁸⁸³ *Ibid.*, paras 1-3.

⁸⁸⁴ *Ibid.*, para 7.

⁸⁸⁵ *Ibid.*, para 56.

⁸⁸⁶ *Ibid.*, para 57.

⁸⁸⁷ *Ibid.*, paras 64-71.

an improvement/ prevent deterioration in health. In severe anorexia nervosa, capacity can be compromised in all areas due to the lack of or fluctuating insight, or occasionally organically - impaired cognitive function. In severe chronic cases, capacity becomes central as clinicians; patients and carers face difficult questions over treatability and what is in the patient's best interest. This also begs the question whether a diagnosis of a mental disorder such as anorexia nervosa is sufficient to justify the use of compulsory powers. Clough notes that in practice a presumption already exists that the anorexic body lacks the capacity to reject involuntary intervention.⁸⁸⁸ Lack of capacity cannot therefore be established by the way a person looks, presents himself or by placing significance on a behavioural defect of a person, which raises unjustifiable and unfair suppositions about his capacity.⁸⁸⁹ Case law demonstrates little by the way of developing legal understanding of the complexity of anorexia and the impact on the abilities of those with the condition. Constantly establishing the incapacity of the anorexic body demonstrates the incompatibility of the MCA 2005 with the provisions of the CRPD.⁸⁹⁰ Kong et al notes that there are still no uniform arrangement in the implementation of the empowering tenets of the MCA 2005 with relevance to Article 12 of the CRPD which affirms "equal recognition before the law".⁸⁹¹ Article 12 (2) recognizes that "persons with disabilities enjoy legal capacity on equal basis with others in all aspects of life".⁸⁹² To fully realise the objective and intention of the MCA 2005, priority should shift to the restrictions on the anorexic body to express their autonomy to refuse intervention. A more balanced mechanism for judicial proceeding would focus on their best interest being inclusive

⁸⁸⁸ Clough, op. cit.

⁸⁸⁹ Mental Capacity Act 2005 s 2(3) (a-b).

⁸⁹⁰ Clough, op. cit.

⁸⁹¹ Kong *et al* op. cit.

⁸⁹² CRPD, Article 12(2).

of their experiences, values, decisions and wishes, which should take precedence in judicial decision-making.

Since the introduction of the CRPD, there have been intensified demands for supported decision-making, which align with the notion of autonomy.⁸⁹³ The interpretation of the CRPD enabled a change from the strict legal narratives towards extending greater freedom by validating their ability to make their own decisions thus removing the sole decision making from substituted authority. If the provisions of the CRPD is intended to support decisions of individuals deemed unable to do so then the question will arise regarding how best can the best interest of the individual be supported during interventions.⁸⁹⁴ One way of validated support is by medical professionals accepting and allowing the decision and choices of the person regardless of how rational or irrational they appear. By relinquishing decision-making authority, medical practitioners will transfer control to the individual as sole decision-makers in the invasion of their bodily integrity.⁸⁹⁵ However, support by medical practitioners will be administered in form of supervised influence in the way the person's decisions are formulated and implemented. Craigie recognises that a balanced medico-legal approach would encourage self-expression not at the expense of suppressing freedom.⁸⁹⁶ Interpreting how best to support the wishes and values of the person is not easily arrived at and in practice, it might entail extending the liberty to fulfill their wishes and choices by influencing a person to make better choices and decision, however there is still the likelihood the person's autonomy might be undermined.⁸⁹⁷ Huxtable however recognises that not only are the current medical terrain complex

⁸⁹³ Craigie, *op. cit.* pp.398-405.

⁸⁹⁴ *Ibid.*

⁸⁹⁵ *Ibid.*

⁸⁹⁶ *Ibid.* pp.89-90.

⁸⁹⁷ *Ibid.*

but so are emerging persons with mental disorders, it will therefore be unrealistic to uphold strict value systems with a compromise that can reintroduce the wishes, choices and decisions of the persons at the center stage.⁸⁹⁸ In fulfilling the question of autonomy, medical narrative would first establish if the patient wants the intervention. Once autonomy is established, there is then the question of whether the supposed intervention is in her best interest and then further implication of public interest is taken into full account.⁸⁹⁹ Autonomy should therefore not be regarded as non-existent where welfare is significant. The welfare of the individual should be a reflection of how well their autonomous values are determined.⁹⁰⁰

The intention of the CRPD should not be over-stretched beyond recognizing that disabled individuals do possess equal rights, though there is a huge reliance on the state to implement and actualize these rights.⁹⁰¹ CRPD is therefore not intended to force the compliance of the courts to permit the values and wishes of the individual. The meaningful nature of their self-starvation establishes value and choice, which provides solid bases to establish mental capacity. The CRPD therefore only offers a reinforcement of established pathways that the court would adhere to in order to ensure the safe guard of human rights. Current judicial decisions only further strict paternalistic enhancing procedures, which focus on granting permissions for self-expression rather than building on the inherent freedoms of the individual regardless of their psycho-social or mental status. For the application of best interests to reflect a balance between the MCA 2005 and the CRPD, the question is not on how the courts can grant the wishes of the person to be included in their own decision-making and

⁸⁹⁸ Richard Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Value of Medical Law' (2014) 22(4) Medical Law Review pp.459-493.

⁸⁹⁹ *Ibid.*

⁹⁰⁰ *Ibid.*

⁹⁰¹ Clough, *op. cit.*

the impact of such decisions on the court process. Rather a meaning centered approach, which ensures that decision-making is decentralized in a way that allows the anorexic body to be the key participant determination of treatment option and declining intervention does not result to the conclusion of incapacity. In securing the best interest of anorexic body adjudged to lack capacity, focus should be placed on individualized voice of the person, which validates their choice of refusing involuntary intervention. Coggon recognizes the need for the law to evolve in practice by attributing the same weight to those who have capacity and those deemed to lack the capacity to make decisions.⁹⁰² Revision of the law in totality may be a far stretch however correctly interpreting the law to reflect a balance between the intertwined medical and legal control alongside the subjective directive of what represents the person's best interest.⁹⁰³ Whether capacity is established or not, implementing a mechanism that ensures that their meaningful preferences are adhered to, only then can the presumed incapacity of the anorexic body be silenced.⁹⁰⁴

6.2 Involuntary Treatments

The DSM-5 is predominantly viewed as a clinical tool,⁹⁰⁵ intended to establish medical guidelines by stipulating the psychiatric diagnostic criteria for clinicians to identify, evaluate and proffer treatment for distinct mental disorders.⁹⁰⁶ The revised 5th edition (2013) created a classification of mental disorder⁹⁰⁷ and is currently the

⁹⁰² Coggon, *op. cit.* pp.396-414.

⁹⁰³ *Ibid.*

⁹⁰⁴ *Ibid.*

⁹⁰⁵ Kamryn T. Eddy, David J. Dorer, Debra.L. Franko, Kaviita Tahlani, Heather Thompson-Brenner and David B. Herzog, 'Diagnostic Crossover in Anorexia Nervosa and Bulimia Nervosa: Implications for DSM-V' (2008) 165 (2) *The American Journal of Psychiatry* p.245.

⁹⁰⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (5th ed. 2013).

⁹⁰⁷ Vijay J. Mitfal, and Elaine F. Walker, 'Dyskinesias, tics, and Psychosis Issues for the next Diagnostic and Statistical Manual of Mental Disorders' (2011) 189 (1) *Psychiatry Research Journal* p.158.

“dominant psychiatric system used around the world”.⁹⁰⁸ The DSM categorical classification system is in line with the official coding system of the World Health Organisation’s International Classification of Diseases (ICD)⁹⁰⁹. In addition to providing for a diagnostic criterion for anorexia nervosa, the DSM-5 also sets guidelines for clinical evaluation of body weight margins to assist clinical evaluation and ultimate differentiation between a healthy body and the ‘sick’ body.⁹¹⁰ Treatment professionals therefore rely on the factors identified in the DSM-5 and by extension the ICD for identifying the behavioural patterns or symptoms needed to deconstruct both what consists of the mental elements and the physical indicators as a result of starvation. The DSM’s careful corresponding with the ICD reconciles the attitude for clinical approach in involuntary treatment of persons whose diagnosis fulfil the highlighted behavioural patterns or diagnostic symptoms of anorexia. However only the most obvious symptoms are recognized during clinical diagnosis thereby understating the cluster of less prominent symptoms, which in retrospect should form the core basis of symptoms that fulfil the diagnostic criteria. In this regard, the DSM classification reveals a variation of structural problems most related to the lack of recognition of other multiple indicators which might be present due to a person suffering from multiple illness at once. Questions arise on the best approach to effectively dissect a cluster of disorders to “maximize their validity and clinical utility”.⁹¹¹

⁹⁰⁸ Helen L. Egger and Emde N. Robert, “Developmentally-Sensitive Diagnostic Criteria for Mental Health Disorders in Early Childhood: DSM-IV, RDC-PA, and the Revised DC: 0-3’ (2011) 66(2) The American Psychologist p.98.

⁹⁰⁹ *Ibid.*

⁹¹⁰ Manuel Focker, Susanne Knoll and Johannes Hebebrand, ‘Anorexia Nervosa’ (2013) 22(1) European Child Adolescent Psychiatry p.29.

⁹¹¹ *Ibid.*

Assessing the competence of an individual to make their own treatment decision has both ethical and legal implications.⁹¹² Douzenis and Michopoulos recognise that the controversy around the care and management of individuals with eating disorder revolves around their refusal of psychiatric treatment and hospitalisation.⁹¹³ Research outcome reveals the impact of coercing an individual to accept treatment against their will. The impact of voluntary treatment often occasioned with the use of force when necessary is severe and individuals do not sustain any long benefits.⁹¹⁴ In *NHS v X*, Dr. A considered involuntary treatments as “clinically inappropriate, counterproductive and increasingly unethical.”⁹¹⁵ Involuntary treatments were shown not to be effective in addressing the underlying anorexia of Ms. X. The treatment professionals unanimously agreed that involuntarily treating X would include⁹¹⁶ “painful, invasive and wholly unwelcomed procedures for X, but would be pointless in terms of achieving long-term treatment”.⁹¹⁷ Involuntarily feeding X would only provide a very faint possibility of reversing her weight loss and preserving her life.⁹¹⁸ At that stage, it has become evident that the involuntary treatment mechanism relied upon by medical practitioners and the law lacked the overall ability to necessitate full recovery or protect the best interest of the individual.

Douzenis and Michopoulous therefore argue that although there exists a possibility for preservation of life, however there is a greater likelihood of abandoned treatment. Lack of clarity surrounding diagnostic boundaries provides the unhinged paternalistic

⁹¹² Bridgman, *op. cit.* pp.387-392.

⁹¹³ Athanasios Douzenis, and Loannis. Michopoulous ‘Involuntary Admission: The Case of Anorexia Nervosa’ (2015) 39 International Journal of Law and Psychiatry pp.31-35.

⁹¹⁴ *Ibid.*

⁹¹⁵ *NHS v X* [2014] EWCOP 35, para 3.

⁹¹⁶ *NHS v X* para 4.

⁹¹⁷ *Ibid.*

⁹¹⁸ *Ibid.*

freedom for treatment practitioners to explore depths of mental deterioration with ethical significance. It is acknowledged that it is unlawful to impose treatment on competent individuals. Acts of involuntary treatment on individuals considered competent may result in criminal charges of battery and “tort of trespass”.⁹¹⁹ The use of force and restraint is traditionally connected with crime and criminal handling; it poses a legal wrong to apply such force on individuals or adults outside the confines of statutes and common law. Section 64 a(b) of the Mental Health Act 1983 provides that medical treatment should be solely for “the mental disorder from which the patient is suffering”.⁹²⁰ There is therefore no clarification for imposing treatment to correct the physical disorder. Bridgman notes that the undefined boundaries between what constitutes a physical disorder and mental disorder have enabled “the courts to utilise this section and declare that some treatments (including reasonable restraint) would be lawful despite the patient’s refusal”.⁹²¹

The mental health laws already provide the free hand for clinicians to approach decision making with no overwhelming need to engage with the multifactorial meanings underling the anorexic body. When decision-making capacity is not established, paternalistic intervention is eminent. Dworkin describes paternalism as the use of personal coercion and interference with a person’s freedom of action “justified by reason referring exclusively to welfare”.⁹²² Brain Mckinstry points out that majority of proponents of paternalism describes paternalism as a situation when the doctor does not undertake the consent of the patient; believing consent was given

⁹¹⁹ Bridgman, *op. cit.*

⁹²⁰ Mental Capacity Act 1983, S 64(a-b).

⁹²¹ Bridgman, *op. cit.*

⁹²² Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge, Cambridge Press 1988) p. 2.

automatically and therefore sees no need to seek consent from the patient.⁹²³ Mckinstry explains that a doctor however acts paternalistically when he or she comes to the realization that consent would not be given by the patient but progresses to treat the patient to fulfil the welfare interest. Medical treatment decisions in anorexic cases are a matter of clinical judgement and judicial proceeding has shown to be tilted in favour of clinical judge thus furthering stereotypes and assumptions. Medical practitioners were solely vested with the duty to make the delicate decision on whether to impose treatment methods such as nasogastric feeding, and other invasive approaches, which in retrospect do not include the values, wishes or consent of the person. The challenge is to establish a balanced decision which values a patient's best interest on one hand and prevents any form of damages arising from lack of nutrition on the other.⁹²⁴

Medical treatment of the anorexic body involves compulsory hospitalization, use of physical restraint and force-feeding.⁹²⁵ In *Riverdale Mental Health NHS Trust v Fox*, an ex parte order was granted allowing the force-feeding of the anorexic person in accordance with section 145 of the Mental Health Act. Force-feeding was considered a treatment for mental disorder although section 145 (F33) of the act provides that medical treatment should only include "nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care".⁹²⁶ In *NHS v L*, Ms L was subjected to nasogastric tube feeding as part of the medical treatment for her

⁹²³ Brian McKinstry, 'Paternalism and the Doctor-Patient Relationship in Practice' (1992) 42(361) British Journal of General Practice pp. 340-341.

⁹²⁴ Tomas J. Silber 'Treating of Anorexia Nervosa against the Patient's Will: Ethical Considerations' (2011) 22 Adolesc Medical State Article Review pp. 283-288.

⁹²⁵ Re C (A Minor) (Medical Treatment) [1997] 2 F.L.R.

⁹²⁶ *Riverdale Mental Health NHS Trust v Fox* 1994]1 FLR 614, 619).

eating disorder.⁹²⁷ Force-feeding L via a nasogastric or PEG tube was achieved using chemical sedation against L's wishes. Re-feeding and forceful detention was authorised and considered a valid medical treatment in Re C (Detention: Medical Treatment).⁹²⁸ The complexities involved in treating and managing an anorexic patient are gradually emerging from obscurity to better understanding in the fields of medicine, psychiatry and law.⁹²⁹ Clinicians have also established that most critical stages of anorexia nervosa have severe impact on the psychological, emotional, social and economic wellbeing of a sufferer. There is however no misconception that this form of mental illness has been proclaimed by clinicians as severe, relentless⁹³⁰ and can invariably result to very significant medical impairment, disability and death.⁹³¹ The medical consequences are grave and in severe cases can lead to death. In cases where a person succumbs to this disorder, it is difficult to determine what method of treatment could aid recovery and restore the sufferer to their previous healthy state. Prolific cases of persons who voluntarily succumb to starvation and how they are treated or cared for against their will has been one of the core reason of research into anorexia nervosa.

Treating or managing this form of mental illness is therefore by no means a straightforward process and in most cases involves a multiple approach from diverse fields. For a person diagnosed with anorexia, life would never be the same as restrictive methods imposed during the treatment and care of anorexia nervosa patients are often unconsented to. Plagued with unconsented interference, detentions and involuntary treatments, it becomes a critical struggle for an anorexia nervosa

⁹²⁷ The NHS Trust v L and Others [2012] EWHC 2741 (COP).

⁹²⁸ Re C (Detention: Medical Treatment) [1997] 2 FLR 180.

⁹²⁹ Crisp, *op. cit.*, pp. 3-8.

⁹³⁰ *NHS Trust v L* [2012] EWHC 2741 (COP) para.1.

⁹³¹ Brunch, *op. cit.*

patient to have any control in making treatment decisions over her mental and physical health. It therefore follows that no matter how liberal a diagnosis may appear, paternalistic intervention is immediately initiated to impose involuntary treatments in an effort to manage the ailment and understandably aid physical recovery. Setting their autonomous rights to the side, clinicians step in on the basis that relieving the symptoms of the illness will amount to relieving the cause of the illness. The next step would involve the decision on whether to detain the sufferer for assessment before treatment is approved. Then there is the determination on the appropriateness or to some extent the legality of imposing involuntary feeding or force-feeding which is always the main treatment choice in severe cases of anorexia nervosa. The anorexic body have little or no say in making their treatment decisions and are therefore treated against their will.⁹³²

Glover-Thomas in *NHS v L* argued that the nature of anorexia nervosa is more complex than a mere pursuit of thinness as this psychiatric illness impairs the way the brain and mind functions leaving the sufferer with an exaggeration of what her actual body proportion or shape is.⁹³³ In *W (A minor)*, it was argued that the presence of a mental illness is an impairment that distorts a person's better judgement in making treatment decisions and renders them incompetent.⁹³⁴ The first phase after establishing incompetence is the critical decision aimed at aiding the patient's recovery by relieving the physical symptoms. Attention is not given to whether treatment such as re-feeding addresses the mental disorder, which is the underlying cause of the illness. Giordano emphasises that the abnormalities of a person's feeding pattern is not a symptom associated with their mental illness as clinicians often argue.

⁹³² Kluge, *op. cit.*

⁹³³ *NHL v L*, *op. cit.*

⁹³⁴ *Re W (A minor) (Medical Treatment Courts Jurisdiction)* [1992] 4 All E.R.

Therefore, there is “no ethical justification for the different treatment that the law reserves for people who have received a psychiatric diagnosis”.⁹³⁵ There is therefore a considerable dissimilarity between applying ethics in regulating the disease agents and in controlling the behaviour of the host.⁹³⁶ The several critiques of paternalistic approach to treating anorexic patients reveals that doctors assumes the power to make decisions for people thereby preventing the person from fulfilling what they set out to do by attempting to substitute one’s judgment for theirs, expressly for the purpose of promoting their welfare”.⁹³⁷ According to Warren, the critiques of paternalism shares same view point as Mill’s principle of libertarianism which emphasizes that the only reason to use force or coercion over another member of a civilized community without his consent should be only for the purpose of preventing harm on another human being “his good, either physical or moral, is not a sufficient warrant”.⁹³⁸

Warren recognizes that Mill was against the paternalistic defense of acting in the best interest of a patient when such interest excludes the patient’s beliefs, values, decisions and expectations on the issue.⁹³⁹ There is also the criticism of a likelihood of abuse or negligence when exclusive powers are given to doctors or treatment practitioners to administer whatever treatment they deem fit without an accountability mechanism.⁹⁴⁰ The fundamental principles of the sanctity of life are however not absolute although engraved in many factors. One of these factors extends to the duties of treatment professionals to care for and take delicate decisions on behalf of an anorexic patient.

⁹³⁵ Giordano, *op. cit.*, p.6.

⁹³⁶ David R. Buchanan, ‘Autonomy, Paternalism and Justice: Ethical Priorities in Public Health’ (2008) 98(1) American Journal of Public Health pp.15-21.

⁹³⁷ *Ibid.*, pp. 2-3.

⁹³⁸ R. Warren, Dialectic Paternalism in Medical Ethics: A Critique (2011) available at <http://dialecticonline.wordpress.com/issue-06-summer-10/paternalism-in-medical-ethics-a-critique/> [accessed 5th May 2019].

⁹³⁹ *Ibid.*

⁹⁴⁰ *Ibid.*

This duty of care for a patient's life is however not an absolute obligation of the doctor as the principle of sanctity of life does not compel a doctor to treat a patient of sound mind who refuses treatment and would die as a result of such refusal. It does not authorise similarly forcible feeding of patients of sound mind who are on, for whatever reason decide to self-starve.⁹⁴¹ To make the delicate decision on whether to feed or not feed someone who refuses food always raises reasonable conflict and significant concern on how to preserve their sanctity of life and at the same time honour the inherent rights of the anorexic patient to self-determination.

Medico-legal discourses on the involuntary treatment of the anorexic body are established on the incompetence and incapacity of the anorexic body to voluntarily consent to treatment given their mental imbalance. Clinicians insist that involuntary treatment methods are not only essential to rectify physical emaciation but intended to correct other non-normalized behavioural patterns categorised as mental disorder or illness. Standard medical approach towards individuals diagnosed as mentally ill is involuntary treatment mechanisms to prevent further mental deterioration and in most cases ultimately correct pre-determined mental disorder. The legal references for administering involuntary treatments on persons diagnosed with various forms of mental disorders are sections 2 and 3 of the Mental Health Act 1983.⁹⁴² Section 63 of the Mental Health Act 1983 removes the requirement of consent before treatments.⁹⁴³

⁹⁴¹ Richard S. Harper, *Medical Treatment and the Law: Issues of Consent The Protection of Vulnerable: Children and Adults Lacking Capacity* (Bristol: Jordan Publishing 2014) p.16.

⁹⁴² Rethink Mental Illness, Mental Health Act 1983 available at <http://www.rethink.org/living-with-mental-illness/mental-health-laws/mental-health-act-1983/sections-2-3-4-5#section3> [accessed 11th June 2019].

⁹⁴³ Care Quality Commission, Guidance on the Treatment of Anorexia Nervosa under the Mental Health Act 1983 available at [file:///Users/cynthia/Downloads/CQC%20GN%20the_treatment_of_anorexia_nervosa_under_the_mental_health_act_1983_updated%20\(1\).pdf](file:///Users/cynthia/Downloads/CQC%20GN%20the_treatment_of_anorexia_nervosa_under_the_mental_health_act_1983_updated%20(1).pdf) [accessed 10th March 2019].

The medical treatment for anorexia nervosa often requires compulsory hospitalisation, use of physical restraint, and force-feeding.⁹⁴⁴ Giordano points out that:

“Many of these stories narrate episodes of hospitalisation and tube feeding. People tell of how they were forced to stay in hospital and of how they did their best to resist any medical intervention. Exercising in the shower, drinking lots of water and not going to the toilet before being weighed, or eating the way out getting fat enough to be discharged and then, once released starting idiom with anorexia the circle seems endless”.⁹⁴⁵

The approach of judges in anorexic cases has been criticised as ‘seeking by the means of law to bring about the results which the doctor seeks’.⁹⁴⁶ In interacting with self-starving persons, judicial proceedings only recognise the one-dimensional narrative of anorexia. Anorexia nervosa is complex; clinicians fail to take into consideration the disorder, which can affect individual outcomes. *Norfolk & Norwich Healthcare (NHS) Trust v W* reveal a departure from the confines of prescribed detention under the Mental Health Act by identifying and acknowledging a set of individuals who do not possess any form of mental disorder but are still considered to lack the capacity to make their own treatment decision. One can therefore be considered incapable of making decision regardless of the absence of mental disorder. Mental disorder is

⁹⁴⁴ *Re C (A Minor) (Medical Treatment) op. cit.*

⁹⁴⁵ Giordano, *op. cit.*, p. 180

⁹⁴⁶ Andrew Downie, ‘A Metropolitan Borough Council v DB and *Re C* (Detention: Medical Treatment) - Extra-Statutory Confinement - Detention and Treatment under the Inherent Jurisdiction’ (1998) 10(1) *Child and Family Law Quarterly* p.106.

therefore not a prerequisite to be denied the right to refuse involuntary treatment. The implication is that individuals can exhibit behaviours similar to identified mental disordered symptoms but may not be suffering from any mental disorder that is recognizable as the empirical research demonstrated in Calabar Nigeria. It is notable that both competent and incompetent anorexics present similar physical attributes of thinness, weakness and emaciation lending to the vulnerability stereotype. A prior behavioural pattern of an individual, although accounted for at a particular time, should not lend credence for future behaviour. The evidence for compelling involuntary intervention before them are not informed on case-by-case analysis rather it is formed by stereotypical presumptions complied to by the psychiatrist and medical doctors. The courts are not entirely misled as few cases of anorexia fulfil the criteria of inability to retain information, showing signs of aggression and suicide. In very few cases, they show sign of being able to harm themselves and others. In the patient-centered anorexic body, the law fails to recognise that the application of involuntary treatment, especially using any form of force or coercion, is not deemed as part of the act of life preservation rather it strips their dignity. Then again the legal proceedings do not favour the meaning centred anorexics who have demonstrated capacity to understand and retain information. The meaning centred anorexic also have not shown any evidence of suicide or ability to harm others. The goal is not seek an enforcement of their right to die but an acknowledgement of their right to refuse involuntary treatment thereby preserving their values, wishes and decision. In *NHS Foundation Trust v X*, Mr Justice Cobb acknowledged that he reached the decision not to enforce treatment for X's anorexia based on the values and choices of X's decision.⁹⁴⁷ Involuntary intervention neglects one cardinal rule of medical law and

⁹⁴⁷ *NHS Foundation Trust v X* [2014] EWCOP 35.

ethics – “patients have rights”. It is more challenging for those rights to be realised when forging dignity and curtailing liberty is viewed as an essential part of recovery.⁹⁴⁸ Bridgman acknowledged that the law courts are mostly silent on the use of any form of restraint in situations where individuals refuse treatment; the courts instead indirectly evaluate if providing care and treatment for individuals who are adjourned mentally ill is lawful.⁹⁴⁹ The two questions are separate and distinct. The cases where the use of restraint is noted often involve and imply an urgency of death or implied suicide; thus any act of refusal will “suggest” an impaired decision making capacity.⁹⁵⁰ The position of the law therefore excludes individuals who show abnormal behavioural pattern from the list of people who can assert their rights to refuse medical treatment. Their right to make their own decision is not recognised or respected once involuntary treatment procedures are to be implemented.

Blurred boundaries between clinical pre-determined assumption of the outcome of individual anorexic cases are remarkably unmonitored in practice and in theory. Critical legal and ethical consideration arises within involuntary treatment discourses border on consent, best interest, respect of autonomy and ultimately the implication on human rights. Further ethical issues arise based on the justifiability of paternalist intervention where the person refuses to be treated involuntarily. Autonomy to grant or refuse medical treatment has raised significant question “especially in relation to the use of detention and reasonable force to effect life-saving treatment for adults”.⁹⁵¹ English court’s jurisdiction at common law to improve involuntary medical treatment is somewhat straight forward in matters relating to children however a few decisions

⁹⁴⁸ Peter De Cruz, ‘Adolescent Autonomy, Detention for Medical Treatment and Re C’ (2003) 62 (4) *The Modern Law Review* pp.555-604.

⁹⁴⁹ Bridgman, *op. cit.*

⁹⁵⁰ *Ibid.*

⁹⁵¹ Cruz, *op. cit.*

have been implemented outside the confined spaces of the Mental Health Act 1983. Preliminary examination of core decided cases reveals unconventional and controversial methods of involuntary treatment of patients diagnosed with anorexia nervosa. An in-depth analysis reveals a pattern where the intervention of medical practitioners supersedes the patient's rights to autonomy and consent prior to any medical treatment. In these situations, the right of a person to refuse treatment is second-tiered, trumped by paternalistic considerations, which might involve coercive patterns.⁹⁵²

Bridgman argues that there is no possibility of providing care to patients who resist them without exerting some control over their behaviour in some way.⁹⁵³ The impact of using restraint or other invasive treatment methods as part of the treatment for mental disorders trumps psychiatric justification. The implication is that the rights of the sufferer are trampled upon in this process. Hence, embracing a broader framework of a symbolic reasoning begins with revolutionary objections to the justification for the enforceability of such treatments, which give priority to the physical recovery of the patient rather than their choice to live as they please. Only a handful of authors echo Rosalyn Griffith's strong convictions that there is no stipulation that forced feeding or nasogastric therapy represents a form of treatment enforceable under the Mental Health Act 1983.⁹⁵⁴ This anti-involuntary treatment echo is yet to establish an enforceable structured rights framework. Accordingly, clinicians are not reluctant to

⁹⁵² Stephen Touyz and Terry Carney, 'Compulsory (Involuntary) Treatment for Anorexia Nervosa' (2010) Sydney Law School Legal Studies Research Paper No (10/07) available at <https://poseidon01.ssrn.com/delivery.php?ID=420125003002079001094004094077112092096020034023025001122072001066081020031113002071005059060034023051016025108103125012067007046078006069052031078083011071029108021001016105087071122005028021072112105101086122028123028101080081124071027096112078127&EXT=pdf> [accessed 15th May 2018].

⁹⁵³ Bridgman, *op. cit.*

⁹⁵⁴ Griffiths, et al. , *op. cit.*, pp. 127-150.

test the boundaries of rights violation with certain paternalistic reasoning and validation. Siostrand et al recognise that involuntary treatments are any unwanted psychiatric or non-psychiatric actions, which go against the informed consent, or free will, of an individual.⁹⁵⁵ According to Griffiths, et al decades ago, clinicians such as Lasagne, Charcot, and Gull deliberated over same issues surrounding the justification for involuntary treatment of mentally ill patients.⁹⁵⁶ For individuals clear of any form of disordered behaviour, the requirement of consent is mandatory before any treatment. However, the lines between involuntarily treating mentally ill and non-mentally ill individuals remain blurred in practice. Mainstream research show that in this modern and theoretically liberal society, issues surrounding involuntary or compulsory treatments persist and remain unresolved.⁹⁵⁷ Reviewing the research conducted by Salize, et al on the ‘compulsory admission and involuntary treatment of mentally ill patients-legislation and practice in EU-member states’,⁹⁵⁸ it is apparent that involuntary treatments are contentious because of the enormous effect it has on the personal autonomy, self-determination, and freedom of choice of the human body.⁹⁵⁹ Most arguments about eating disorder point out that the sole purpose of involuntary treatments (by means including psychotherapy and re-feeding) is to preserve life and ensure the individual does not succumb to death. However, such treatments carried out without a person’s consent has also been proven not to be the

⁹⁵⁵ Manne Sjostrand, Lars Sandman, Petter Karlsson, Gert Helgesson, Stefan Eriksson and Niklas Juth (eds.), ‘Ethical Deliberations about Involuntary Treatment: Interviews with Swedish Psychiatrists’ (2015) 16(1) BMC Medical Ethics available at <http://bmcomedethics.biomedcentral.com/articles/10.1186/s12910-015-0029-5> [Accessed 10th October 2019].

⁹⁵⁶ Griffiths, et al. *op. cit.* p. 129.

⁹⁵⁷ M. Bentoyim, ‘Ethical and Legal Issues’ in Bryan Lask and Rachel Bryant-Waugh (eds.), *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence* (London, Psychology Press 2000) p. 352.

⁹⁵⁸ Hans Joachim Salize, Harald Dreßing and Monika Peitz, (2002) ‘Compulsory Admission and Involuntary Treatment of Mentally Ill Patients-Legislation and Practice in EU-Member States’ available at http://ec.europa.eu/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf [accessed 10th August 2019] pp. 1–6.

⁹⁵⁹ *Ibid.*

most effective in tackling any significant mental and physical aspects of the anorexic body.

Coercive and forceful involuntary treatment methods, such as force-feeding, on anorexic patients are questionable basic human rights issues. First we can consider the mundane routine of living in an institutionalized system. Noteworthy is the day-to-day activities of involuntarily treated patients who are embedded in disciplinary, coercive, regimented and controlling routines which border on undermining the fundamental rights and freedoms entrenched under the ECHR. These institutionalized rituals very much infringe on the freedom and liberty and to a significant extent, the self-image, bodily integrity, identity and dignity. The use of force or coercion during involuntary treatments for mental illness is, therefore, contestable. Nevertheless, devoid of a legitimate enforcement mechanism, this argument will remain a mere theoretical perspective.⁹⁶⁰ Generally, to force-feed or detain someone when they refuse it can give rise to both criminal and civil liabilities.⁹⁶¹ It is also a violation of their fundamental rights to privacy and personal autonomy entrenched under Articles 3 and 8 of the ECHR.⁹⁶² It is fair to establish that the complexity of this illness places anorexia nervosa sufferers at the lower end of vulnerability needing greater rights protection under the law.⁹⁶³

The uprising in liberties objections questioning the impact of involuntary treatment mechanisms during medical interventions⁹⁶⁴ furthers the conviction that involuntary

⁹⁶⁰ Griffiths, *et al op. cit.*, p. 178.

⁹⁶¹ Kluge, *op. cit.*

⁹⁶² ECHR, Convention for the Protection of Human Rights and Fundamental Freedom available at http://www.echr.coe.int/Documents/Convention_ENG.pdf [accessed 4th of March 2019].

⁹⁶³ Wicks, *op. cit.*, pp.17-40.

⁹⁶³ *Ibid.*

⁹⁶⁴ Terry Carney, Miriam Ingvarson and David Tait, 'Experiences of "Control" in Anorexia Nervosa: Delayed Coercion, Shadow Law, or Disseminated Power and Control' in Swain, P. (ed.) *Anorexia Nervosa and Bulimia: New Research* (New York, Nor Science Publishers 2006) p. 55.

treatment presents a major emblematic challenge for both ethics and human rights.⁹⁶⁵ Scientific research and empirical studies in this field are far from complete, the underlying paternalistic framework present only fuel-unsettled debates on the legal standards and procedures that authorise involuntary treatment and hospitalisation of mentally ill patients, with particular reference to the anorexic body.⁹⁶⁶ The outcomes of these debates show no tangible or practical evidence of furthering the autonomous rights of these patients as they still appear to be massively restrained. As such, drawing on legal rules, which fuel *ad hoc* paternalism without any consideration for the moral, social, and political concepts relating to anorexic body is unrealistic and impractical in today's millennial age.⁹⁶⁷ Following the writings of Giordano, Bordo, Dresser, and Dolan, clinicians may still justify the preservation of life above anything else. It is important that the anorexic body be first recognised, as a cultural metaphor for self-determination.⁹⁶⁸ Therefore, anorexics should be treated with their informed consent, participation, and liberty, which forms the bedrock for expressing their autonomous rights.⁹⁶⁹ It is, therefore, necessary to constantly review the way people consciously living with anorexia nervosa are treated to ensure that the ethical doctrines of "beneficence, autonomy, non-maleficence, justice and utility are balanced and aligned".⁹⁷⁰ The law should therefore respond fundamentally to the meaning-centred anorexic body and align with an ethical decision-making model which emphasises the extensive features of the person's principles, culture and gender

⁹⁶⁵ Terry Carney, 'Anorexia: A Role for Law Therapy?' (2010) 10(5) Social Science Research Network Electronic Library available at [file:///Users/cynthia/Downloads/SSRN-id1531975%20\(1\).pdf](file:///Users/cynthia/Downloads/SSRN-id1531975%20(1).pdf) [Accessed 12th September 2019]

⁹⁶⁶ Rebecca Dresser, 'Feeding the Hunger Artist: Legal Issues in Treating Anorexia Nervosa' 1984(2) Wisconsin Law Review p. 298.

⁹⁶⁷ Terry Carney, David Tait, A. Wakefield and D. Saunders, 'Managing Anorexia Nervosa: Clinical, Legal and Social Perspectives on Involuntary Treatment' (2006) 24(1) Medicine and Law p. 24.

⁹⁶⁸ Bordo, *op. cit.*, p. 93.

⁹⁶⁹ Bridget Dolan, 'Food Refusal: Forced Feeding and the Law of England and Wales' in W. Vandereycken, and P. Beumont, (eds.) *Treating Eating Disorders. Ethical, Legal and Personal Issues* (London, Athlone 1998) pp. 139.

⁹⁷⁰ Russell, *op. cit.*, pp. 584.

role. Matusek and Wright suggested adopting an “integrative, collaborative and culturally sensitive ethical decision making model,”⁹⁷¹ which incorporates an agreement of facts through interactive negotiation and inclusion. The essence ensures that there are multi-level systems that can coordinate diverse viewpoints, accommodate a wider spectrum of anorexia nervosa and proffer resolution when conflicts arise. The meaning centred approach can ultimately assist compulsory persons to become voluntary persons through inclusion as stakeholders and participants in decision-making.⁹⁷²

⁹⁷¹ Matusek and Wright, *op. cit.*

⁹⁷² *Ibid.*

CHAPTER 7

Towards A Human Rights Based Approach

7.

The core aspect of the thesis rests on answering four leading questions: a). What is a meaning-centred anorexic body and can this approach to self-starvation redefine anorexia as not exclusively a psychiatric condition? b). Are involuntary treatments in the best interests of the anorexic body and can the Mental Health Laws in the UK recognise the autonomous rights of the anorexic body? c). Can a meaning-centred anorexic body be identified in non-western cultures and is there significance in addressing medical and psychiatric stereotypes and labelling? d) Are there human rights implications in the enforcement of involuntary treatments on the meaning centred anorexic body under the European Convention on Human Rights (ECHR)?

Chapters 2, 3, 4, 5, 6 comprehensively explores the first three questions through the conceptual analysis of the meaning centred anorexic body as a bearer of rights by ensuring that their valued choices and experiences within health care are recognised. These are fundamental socio-legal analysis that precedes the analysis in Chapter 7. Sensitivity and respect for individualised ways of life and reasoning have not always been well received, thereby making third party imposition of choices the norm. Invariably, different factors are in consideration within the width of the discretion of those in authority, especially concerning individual liberty. The previous chapter explores the impact of involuntary treatment and the challenges for ethics and human rights. This chapter recognises that human rights based approaches are often contested when the medical capacity to treat the disorder is challenged by the awareness of the

rights to refuse care. The conflicts then peak when the paternalistic approach of responsible society clashes with the autonomous rights of the individuals. Involuntary decisions without the consent or approval of the individual are considered adverse to rights advocacy for freedom and autonomy. Reviewing clinical and medical care pattern from a human rights angle and fostering while analysing the inherent rights of freedom of choice, decision-making and autonomy is the core of this research.⁹⁷³ Chapter 7 explores the notion that human rights considerations should precede involuntary medical intervention by inclusion of individuals as active or sole participants in the decision-making process. This chapter, therefore, attempts to establish the underpinnings for a right-based approach grounded by the inclusion of their instinct values and personhood, thereby creating the bases for autonomous choices. The aim is to analyse the extent of rights protected or fulfilled under the ECHR, enabling the individual to implement self-starvation independently without the fear of control and coercion.

a. Human Rights-based Approach

The human rights-based approach places the respect, protection, and fulfilment of the human rights of a person at the center in all decision-making processes.⁹⁷⁴ A human rights-based approach, therefore, establishes that greater freedom should be given to

⁹⁷³ Ms B v An NHS Hospital (2002) EWHC 429 (FAM) where Ms B made a plea to exercise her right and stop invasive artificial ventilation treatment. The court's decision confirmed the fundamental principle of autonomy, that every person's body is inviolate. Although a person has the right to refuse treatment but that while a patient's capacity is assessed, they should be treated in accordance with their best interest.

⁹⁷⁴ Care about Rights, 'What is a Human Rights Based Approach?' available at <http://careaboutrights.scottishhumanrights.com/whatisahumanrightsbasedapproach.html> [accessed 3rd January 2019].

individuals,⁹⁷⁵ to partake in any critical decision-making that can affect their human rights.⁹⁷⁶ Dominant paternalistic approach in medicine engages rights fulfilment and protection as secondary to enforcing life-saving treatments regardless of the implication and overall outcome. Clinicians rely on fulfilling diagnostic criteria furnished in the Diagnostic and Statistical Manual of Mental Disorders to establish diminished cognitive function, which prevents an individual from making voluntary decision to feed.⁹⁷⁷ For the anorexic body, administration of treatment does not only involve the application of drugs for the treatment of the mental disorder, further cohesive approaches are taken during treatment process. First, there is involuntary detention, which might include the use of physical force, and then force-feeding (intravenous feeding, gastrostomy and tube feeding) which constitutes part of the treatment regimen. Weingarten and Hebert note that re-feeding and administering food “remains the drug of choice”.⁹⁷⁸ Aside from the unethical implications of force-feeding, there are strong indication that the act of forcefully re-feeding an emaciated body in itself can be life threatening.⁹⁷⁹ Understudied are the side effects of force-feeding, which include anxiety, “deepening of psychological illness and curtailment of liberty”.⁹⁸⁰ The application of forced nutrition and hydration on the anorexic body is based on medical analysis of competence rather than appropriateness of imposing nutrition. At all times, the appropriateness of granting autonomy or allowing participation in decision-making is mainly dependent on clinical evaluation of mental

⁹⁷⁵ *Ibid.*

⁹⁷⁶ United Nations Children Fund, ‘Human Rights Based-Approach: Statement of Common Understanding’ (2005) pp. 91–93 available at <http://www.unicef.org/sowc04/files/AnnexB.pdf> [Accessed 18th November 2018].

⁹⁷⁷ Eating Disorder Hope, ‘Legalities of Force-Feeding an Anorexic Patient’ (2017) available at <https://www.eatingdisorderhope.com/blog/legality-force-feeding-anorexic-patient> [accessed 13th April 2018].

⁹⁷⁸ Philip C. Hebert and Michael A. Weingarten, ‘The Ethics of Force-Feeding in Anorexia Nervosa’ (1991) 144(2) Canada Medical Association Journal p.142

⁹⁷⁹ Eating Disorder Hope, *op. cit.*

⁹⁸⁰ Herbert & Weingarten, *op. cit.*

competence rather than the best interest of the individual. Once mental competence is established, the individual's wishes, decisions (advanced or present) do not form part of the final medical decision on treatment. Patient-centred rights advocacy in the field are emerging and slowly engaging with the ethical challenges of consent, freedom of choice and autonomy.⁹⁸¹ A right-based approach can be effectively applied prior to any medical consideration; only then can a meaningful engagement with the individual successfully occur. This approach is very crucial for the anorexic body because of the treatment approach employed by clinicians to obtain results. A rights-based approach therefore offers the flexibility for advocacy that fulfils the individuals value, best interests while highlighting their voices and incorporating their experience to fulfil their actions. Understandably, it becomes imperative that accountability from persons or institutions responsible for making treatment decisions on behalf of an anorexic body would be assessed within the human rights framework to ensure the fulfilment of their rights.⁹⁸² The ECHR provides for freedom from inhumane and degrading treatment (Article 3), the entitlement to liberty and personal autonomy (Article 5) and the entitlement and respect for private life (Article 8).⁹⁸³ Actions by authorities, individuals or institutions that do not fulfil a person's rights are regarded as acts of violation and challenge to their rights to life, liberty and autonomy.⁹⁸⁴ A rights-based approach will be used to analyse the experiences of the anorexic body including the causes, progression and outcome. Emphasis is, therefore, placed on recognising personal freedom, which includes the liberty to make critical

⁹⁸¹ C.L. Middleton, 'Rights and Respect: Legal and Ethical Issues Challenge Today's Mental Healthcare Professionals' (1991) 72(7) *Health Progress Journal* pp.38-44.

⁹⁸² *Ibid.* p.5.

⁹⁸³ ECHR, Convention for the Protection of Human Rights and Fundamental Freedom available at http://www.echr.coe.int/Documents/Convention_ENG.pdf [accessed 7th August 2019].

⁹⁸⁴ Wicks, *op. cit.*, pp.19–40.

decisions⁹⁸⁵ of which other people do or do not approve.⁹⁸⁶ Critical opposition to curtailing individual liberty or freedom has undergone various philosophical transformations, drawing on arguments of philosophers, such as Mill, Lao Tzu, and Locke, whose views remain monumental and are still relevant in this 21st century. John Stuart Mill poses the question regarding what extent the society has the right to control and impose limitations on the thoughts, beliefs and actions of individuals.⁹⁸⁷ Mill points out that the society has no right to intervene in ‘self-regarding actions’ which only affect the individuals so far those actions do not harm or encroach on the basic rights of another person.⁹⁸⁸ According to Mill, “the individual is not accountable to society for his actions in so far as these concern the interests of no person but himself”.⁹⁸⁹ Chinese philosopher Lao-tzu advocates for the recognition of the rights of personal autonomy and individual liberties.⁹⁹⁰ In retrospect, libertarianism opposes the use of coercive methods on anyone.⁹⁹¹ Wells describes coercion as any action taken concerning the body or property of another human being without their consent.⁹⁹² Drawing from John Locke’s classical libertarian theory, Otsuka insists that individuals should exercise their right of self-ownership which include firm control over their bodies.⁹⁹³ The dignity of an individual becomes non-existent when other people are allowed to exert control over their lives and body. The authorities are, therefore, urged to abide by the policy of ‘*laissez faire*’ meaning that the “authorities

⁹⁸⁵ Tibor R. Machan, *Libertarianism Defended* (Hampshire, Ashgate Publishing Limited 2006). p.11

⁹⁸⁶ *Ibid.*

⁹⁸⁷ David Bromwich and George Kateb, *John Stuart Mill on Liberty: Rethinking the Western Tradition* (London, Yale University Press 2003) pp. 149–152.

⁹⁸⁸ Sam Wells, ‘What a Libertarian Is – and Is not’ (1979) available at <http://laissez-fairepublic.com/libertar.htm> [accessed 7th August 2019].

⁹⁸⁹ Bromwich, *op. cit.*

⁹⁹⁰ *Ibid.*, p.5.

⁹⁹¹ *Ibid.*

⁹⁹² Well, *op. cit.*, p.5.

⁹⁹³ Michael Otsuka, *Libertarianism without Inequality* (Oxford: Clarendon Press 2003) pp. 1–22.

have no business coercively interfering with the lives of peaceful (non-coercive) citizens in their private affair”.⁹⁹⁴

7.1 Historical Conception of Human Rights

The conceptual analysis of developing rights-based principles dates back to the medieval era, uncovering a history marked by prolonged reluctance to embrace a more liberal and fair framework in treating specific sets of individuals. Individuals within a society therefore depend on implementing those principles that ensure both individualised protection and public safety to advance their liberty. It has however been repeatedly articulated that personal preferences and that of the extended society are often at the opposite ends of the spectrum. Emerging paradigm shifts first acknowledge that the predominant negative attitude towards persons with a different skin colour, behaviour and ideologies are well documented. Involving individuals in the debates and negotiations of what signifies their values in terms of respecting their voice has been far in between. Depersonalised or alternative viewpoint on freedoms has always relied on substituted decision making to implement policies that affect an individual.

Historically, universal rights were initially unrecognised and inapplicable curtailing the support for individualised rights-based actions. Human beings therefore existed without directly engaging practical ways to express their freedoms. In context, institutionalised constraints result in interpretative statements of exploitations on a full-scale adverse to individual personhood. Sectional segregation was evident in the

⁹⁹⁴ Wells, *op. cit.*, p.5.

lack of inclusion of a cross section of individuals in decision-making. Similarly, the notion that individuals possessed any form of inherent rights raised concerns on the semantics of such right and the preferred model of implementation. First concerns were how to progressively establish a society, which is capable of recognising that expressions of free will were inherent against a background of laws designed to regulate the conduct and behaviour of individuals. Pressures to develop human rights concepts often met strong resistance as they opposed the accepted way of life, pattern of morality and tradition at the time. The prevalent traditional practices of medieval rulers encouraged inhuman and degrading treatment within a select group therefore fostering inequality. Medieval patterns of oppressions and restrictions of freedoms were the orthodox guide in the institutional practices in the various strata of the society. The deficiency of morality enriched ad hoc patterns of rights restrictions and curtailment without alternative interpretation. In such systems, when a person encountered barbaric and inhuman acts, because remedial platforms were non-existent, ad hoc discrimination and ill treatment became the status quo. Freedom of choice, autonomy and voluntary expression enriched future debates on the best action to cater to the evolving needs of man.

In retrospect, human rights progress was first administered in theory and then transitioned into legal form.⁹⁹⁵ Following that was the national and international recognition of the need to safeguard human rights.⁹⁹⁶ Scholarly accounts of the historical development of human rights often raise questions regarding lack of progression or rights existence during this period. Scholars such as Mbaye firmly asserts that it would therefore be erroneous to trace back the existence of human

⁹⁹⁵ *Ibid.* p.123.

⁹⁹⁶ *Ibid.*

rights to an era, which had no knowledge or familiarity of the importance of upholding and implementing the basic freedoms or solidarity of the people.⁹⁹⁷ The concept of human rights has however progressed from the medieval time where primitive doctrines considered systemically opposed to the enjoyment and fulfilment of rights were in practice and prevalently expressed globally. Algan asserts that positive progression of human rights is now viewed with the aim of “furthering the protection of existing rights at all levels” through a cross collaboration to effectively implement activities that reinforce human rights development.⁹⁹⁸

The conquest of Babylon by Cyrus the Great in 539 B.C and abolition of slavery and promotion of fairness and impartiality between races were the earliest indications of rights potential.⁹⁹⁹ Popularised ideas of the potency of rights movements amounted to debates by various scholars attempting to substantiate their diverse views. Natural law scholars such as John Locke considered human rights “as a given”.¹⁰⁰⁰ John Locke in his second treatise of government proclaims that “men in a ‘state of nature’ were born in a state of equality and inherently possessed ‘natural rights, such as right to life, liberty and property’”.¹⁰⁰¹ Natural law was a concept centred on the premise of the existence of man in the natural state, assuming that the role of right holders whether consciously or unconsciously was certain. The prominent message of naturalists was established in how man can freely interact with nature and unconsciously live within their rights without third party regulations. In the context, accessing the nature and

⁹⁹⁷ Keba Mbaye, ‘Human Rights and the Rights of Peoples’ in Mohammed Bedjaoui (eds.) *International Law: Achievements and Prospects* (Netherlands, Martinus Nijhoff 1991) pp. 1041-1043.

⁹⁹⁸ Algan, *op. cit.*, p.124.

⁹⁹⁹ United for Human Rights, ‘A Brief History of Human Rights’ available at <http://www.humanrights.com/what-are-human-rights/brief-history/> [accessed 2nd April 2018].

¹⁰⁰⁰ Marie-Bénédicte Dembour, ‘What Are Human Rights? Four Schools of Thought’ (2010) 32(1) *Human Rights Quarterly* p.2.

¹⁰⁰¹ Sarah Joseph and Melissa Castan, *The International Covenant on Civil and Political Right: Cases, Materials and Commentary* (Oxford, Oxford University Press 2014) p.3

subject of rights expression was not justified by conceptual theories but by recognizing individualised obligations that emphasised their true state of nature. The natural concept centred on the traditional existence of rights in its true natural state,¹⁰⁰² which reflected on the freedom to implement individualised choices without any restrictions. Prominent in the eighteenth century was the emergence of philosophers who revolutionized and cemented equality as a pathway to democratic advocacy. Guilhot acknowledges the connection between a democratic dispensation and the tenets of human rights.¹⁰⁰³ It therefore followed that the historical advancement of democracy interlinked with securing a global entitlement to human rights.¹⁰⁰⁴ Wicks recognises that advocacy for democratic values requires reliance on securing individual values.¹⁰⁰⁵ Joseph and Castan point out that French philosophers – Rousseau, Montesquieu and Voltaire – expressed profoundly that the true nature of these rights laid in realising the effectiveness of the virtue man possesses. Essentially, understanding effective protection of rights at its core resonates from the imposition of ideals emanating from previous eras.¹⁰⁰⁶ Joseph and Castan therefore recognise that “such rights stemmed from the inherent rationality and virtue of man, championed over the ‘irrational’ scientific and religious dogma which had predominated in the middle ages”.¹⁰⁰⁷ Nevertheless, it is generally believed that the theories of rights change and adapt with the evolution of human beings and the society. It therefore became evident in the seventeenth century that there was a predominant change in the intellectual and conceptual discourse of natural law, emphasizing on the natural rights

¹⁰⁰² John Locke and Peter Laslett, *Two Treatises of Government* (Cambridge, Cambridge University Press 1988) p. 255.

¹⁰⁰³ Nicolas Guilhot, *The Democracy Makers: Human Rights and The Politics of Global Order* (New York, Columbia University Press 2005) pp 2-4.

¹⁰⁰⁴ *Ibid.*

¹⁰⁰⁵ Wicks, *op. cit.*, p.19.

¹⁰⁰⁶ Joseph and Castan, *op. cit.*

¹⁰⁰⁷ *Ibid.*, p.4.

of individuals,¹⁰⁰⁸ founded on the cornerstone of equality and liberty and organized around the concepts of “recognized prerogatives”.¹⁰⁰⁹ Del Russo speaks of human freedom and happiness as an expression of total control physically, mentally and spiritually.¹⁰¹⁰ According to Pillay, the potency of human rights movement has empowered ordinary people to assert their ‘freedom, equality, justice and wellbeing’.¹⁰¹¹

Human rights were also most importantly viewed as a tool to foster peace, liberty, autonomy and fairness for all members of the human race.¹⁰¹² Frankenberg notes the narrative of human rights is presented within a universally relatable vocabulary which challenges deplorable living conditions and misuse of powers.¹⁰¹³ Within those rights is a world that guarantees that conflict resolutions, fair trials, and full participation of disabled individuals in areas of personal interests.¹⁰¹⁴ Reference is often made to the overarching consequences of the denial that human beings possessed rights and could express such rights as they deem necessary with no prejudice. It became obvious pre World War that people were opposed to unconventional practices of expressions and freedoms, which go against the norm. The ideology that individuality of a person’s thoughts, choices, morals and goals can be expressed in a framework not closely monitored or scrutinized was certainly not an acceptable feature. In reality, there were limited choices on the individuals to seek redress and no positive obligation on states

¹⁰⁰⁸ Chidi Oguamanam, *International Law and Indigenous Knowledge: Intellectual Property Rights, Plant Biodiversity and Traditional Medicine* (Toronto, University of Toronto Press 2006) p.62.

¹⁰⁰⁹ Mbaye, *op. cit.*, pp.1049.

¹⁰¹⁰ Del Russo, *op. cit.*, p.178.

¹⁰¹¹ Navanethem Pillay, ‘What Are Human Rights For? Three Personal Reflections’ in Daniel Moeckli, Sangeeta Shah and Sandesh Sivakumaran, (eds.) *International Human Rights Law* (Oxford, Oxford University Press 2014) pp.4-6.

¹⁰¹² *Ibid.*, p.dsx.

¹⁰¹³ Gunter Frankenberg, ‘Human Rights and the Belief in a Just World’ (2014) 12(1) *International Journal of Constitutional Law* p.35.

¹⁰¹⁴ *Ibid.*

to realise the essential features of rights advancement. Objecting rights suppressing measures generated sufficient grants to engage conversations of life and liberty. Slave mastery and trade, obviously, remained prevalent with limited choices and offered no individual protection. The resistance of oppressive regimes had led to temporary triumph however there was still the overarching need for rights-based reconciliation ensuring the injustice of the past does not reoccur.

The United Nations High Commissioner for Human rights in various published articles described human rights as universal, inherent, interdependent, indepen

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indivisible and non-discriminatory.¹⁰¹⁵ “Droits de l’homme”, “derechos humanos”, “menscherechte” all denote “the right of man”. These are the rights a person possesses by the reason of being human – ‘*homo sapiens*’.¹⁰¹⁶ The emphasis on individualised rights reinforces the underlying message of equality and fairness regardless of race, gender or religious background. There is a reconciliation of experiences that are registered as unkind to human beings as embodying injustice. Human beings therefore hardly obscured their quest for other positive elements, which right-based actions attract. Understandably, historical reactions to the construct of human rights remedies have been resisted; regardless purely logical connections have presented a definite pattern of safeguarding rights. The rhetoric of human rights therefore introduces the normative conceptualisation of human right in a way that justifies individual ideal. Generations of the human race pre Hugo Grotius and other philosophers conceptualized the ideals essential to the human existence, identified in detail by post-medieval scholars who were opposed to the idea of the existence of God and inevitably sought to separate morality from the conceptual ideals of human

¹⁰¹⁵ United Nations Human Rights, What are Human Rights? available at <http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx> [Accessed 5th February 2019].

¹⁰¹⁶ Jack Donnelly, *Universal Human Rights in Theory and Practice* (Ithaca, Cornell University Press 2013) p. 2.

rights. The United Nations' intent under the Declaration of Human Rights 1948 was to offer recognition and empowerment to humans to understand, acknowledge and demand their right to be treated with fairness and equality, irrespective of their nationality, colour of skin, religious beliefs or gender. Human transition into right holders inevitably became polarized amongst scholars devoted to theories of freedom. The foundation of rights based solely on humanity and what should be rightfully bestowed on them became a subject for interpretation within variable concepts. Similarly, embedding the search for justice within an unconventional interpretation of rights requires a coherent narrative "to lend credence or rationality to the counterfactual meaning".¹⁰¹⁷ It therefore follows that individual entitlements are justifiable across borders and safeguarding individual from institutional bias is more credible and easy to fulfil. The crucial element is legitimising individual actions that contribute institutional bias. Protecting the interest of the individual, which does not correspond with the exact language of the law, is where the need to engage higher values of dignity and integrity arise. The spirit of the Declaration of Human Rights 1948 affirms the inherent dignity and fundamental principles of freedoms to be upheld by all human beings; this freedom is devoid of governmental intimidation and subjective infringement.¹⁰¹⁸

The urgent clarion call to facilitate human rights safeguard within an already fragile and fragmented society pre-empted the formation of United Nations whose principal purpose was "to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women".¹⁰¹⁹ The adoption of the United Nations' Universal Declaration of Human Rights 1948 (UDHR) after the

¹⁰¹⁷ Frankenberg, *op. cit.*

¹⁰¹⁸ Del Russo, *op. cit.*

¹⁰¹⁹ United Nations, Charter of the United Nations available at <http://www.un.org/en/sections/un-charter/preamble/index.html> [accessed 3rd August 2015].

Second World War¹⁰²⁰ by its General Assembly in Palais de Chaillot Paris was a notable progress in human rights movement.¹⁰²¹ The UDHR encompasses decrees from the time of Cyrus the Great, 17th century natural laws and French declaration of natural rights. The drafting commission chaired by Eleanor Roosevelt endured hours of debates on other key fundamental structures that was inclusive and also exclusive to all human beings. The object or receptor of rights was never an issue or a source of deliberation. It was evident that only humans can own and enjoy rights. This assertion might be too obvious; however, consideration should first be given to what constitutes the human anatomy. The United Nations Charter establishes the principle of respect for human rights in a way that can provide adequate protection. This recognition by the United Nations became the first global acknowledgment of the inherent dignity and equality of all human beings. The UDHR affirms the recognition of the fundamental dignity of both men and women around the world. The recognition was key to the significant promotion of the greater freedom and social progress of mankind. Article 1 of the UDHR reiterates the freedom and equality in dignity and rights of all human beings. Human beings are born with freedom to reason with integrity and the ability to accord the next person with such integrity.¹⁰²² Freedom, dignity and equality are therefore prerequisite for the survival of all human beings. To encourage the spirit of brotherhood, the UDHR provides that actions towards another person must be carried out in good conscience.¹⁰²³ Article 2 grants to everyone the rights and liberties set forth in the UDHR regardless of “race, colour, religion,

¹⁰²⁰ David J. Harris, Michael O’Boyle, Colon Warbrick, Edward Bates and Carla Buckley *Law of the European Convention on Human Rights* (New York, Oxford University Press 2018) pp. 1-4.

¹⁰²¹ Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948) available at <http://www.un.org/en/documents/udhr/> [accessed 10th March 2018].

¹⁰²² UDHR, Article 1.

¹⁰²³ *Ibid.*

political or other opinion, national or social origin, property, birth or other status”.¹⁰²⁴

In retrospect, “no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.”¹⁰²⁵ Article 3 reinforces the right of all mankind to freedom, sustaining life and security.¹⁰²⁶ Article 4 prohibits all forms of slavery including holding a person against their will, transactional slave trades and servitude.¹⁰²⁷ Article 5 prohibits subjecting anyone to any form of treatment regarded as inhumane or degrading including undignified treatments or cruelty.¹⁰²⁸ Article 6 acknowledges the individualised identity of everyone before the law.¹⁰²⁹ Article 7 prohibits all forms of discrimination or discriminatory attitude towards another. Discrimination therefore breeds inequality and prejudice.¹⁰³⁰ Everyone is therefore “entitled to equal protection against any discrimination in violation of the UDHR and against any incitement to such discrimination”.¹⁰³¹ As such all human beings possess unrestricted safeguard against discrimination and other forms of actions that violate the UDHR.¹⁰³² Article 8 gives all individuals access to a competent tribunal when their fundamental rights granted by the law or constitution have been violated. Invariably an individual whom has suffered injustice of any shape can seek adequate solutions and redress under the law. Violating the fundamental right of the individual therefore attracts an effective remedy.¹⁰³³ Article 9 prohibits unlawful arrest for whatever purpose, including the

¹⁰²⁴ UDHR, Article 2.

¹⁰²⁵ *Ibid.*

¹⁰²⁶ UDHR, Article 3.

¹⁰²⁷ UDHR, Article 4.

¹⁰²⁸ UDHR, Article 5.

¹⁰²⁹ UDHR, Article 6.

¹⁰³⁰ UDHR, Article 7.

¹⁰³¹ *Ibid.*

¹⁰³² *Ibid.*

¹⁰³³ UDHR, Article 8.

detention of an individual for purposes unknown to the law.¹⁰³⁴ Article 12 provides for full protection under the law against any external influence or interference. In retrospect, “[n]o one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation.”¹⁰³⁵ Article 18 guarantees “freedom of thought, conscience and religion”.¹⁰³⁶ Article 19 assures everyone the freedom of expression, which “includes the right to hold opinions without interference.”¹⁰³⁷ Everyone is therefore at liberty to seek knowledge and transmit the ideas without any encumbrance.¹⁰³⁸

Similarly, the move by the United Nations presented hope for cynics to embrace emerging ways of implanting rights in reality. The UDHR presented core definition of human rights within constructions of everyday life. Socio-political or cultural settings were therefore not regarded as compromising rights but as informing a better way of understanding rights implication. Gostin notes that protecting human rights was crucial to “prevent the reoccurrence of such egregious affronts to peace and human dignity”.¹⁰³⁹ Theoretically, concrete trend amongst other jurisdictions begins to emerge in recognising the tenets of freedom and liberty. Acts of violations or non-violations of human dignity with any experience began to emerge as purely personal. The motives for rights engagement becomes recognisable as bound to strong patterns of preserving integrity and equality. United Nations envisioned all countries of the world would adopt and incorporate its Charter into their domestic laws in a manner that enhanced individual freedom and safeguarded dignity. Compliance and fulfilment

¹⁰³⁴ UDHR, Article 9.

¹⁰³⁵ UDHR, Article 12.

¹⁰³⁶ UDHR, Article 18.

¹⁰³⁷ UDHR, Article 19.

¹⁰³⁸ *Ibid.*

¹⁰³⁹ Lawrence O. Gostin and Zita Lazzarini, *Human Rights and Public Health in Aids Pandemic* (Oxford, Oxford University Press 1997) p. 2.

of the obligations under the UDHR required the force of law to ensure that inhuman acts or violations were monitored through a system that can guarantee rights protection. The framework of rights existence has undeniably affirmed an implicit value of self-determination by the irrefutable recognition by the international community that all persons are born with a set of privileges recognized as human rights.

The peculiarity of establishing an acceptable framework of human rights advanced the quest for more decisive actions in ensuring safeguards. Institutional safeguards may be elaborate and distant; however, there are situations necessitating exploring beyond the boundaries of third party interests. Quite often, the challenge will be both meeting the expectations of the UDHR and personalizing its contents legitimately. Given the central meanings of what constitutes a just and unjust treatment, individuals are at liberty to justify their reactions without the fear of reprimand. Jilani once posed the critical question “What are human rights for?”¹⁰⁴⁰ Mooney recognised that human rights are in crises due to the urgency of establishing a right based in response to critical questions bordering on the importance of rights protection.¹⁰⁴¹ The emphasis will be on standard definitions of what constitutes rights as well as interpreting it in a manner that resolves the issues of the human kind. Basic codified rights in reality are an assemblage of abstract descriptions that round up the vague ideologies in practice. The emphasis in addressing the significance of human rights is on how its application can advance freedom, justice and equality. It is therefore impractical to comparatively engage in the complex discourse of what human rights signify without connecting

¹⁰⁴⁰ Hina Jilani, ‘What Are Human Rights for? Three Personal Reflections’ in Daniel Moeckli Sangeeta Shah and Sandesh Sivakumaran, (eds.) *International Human Rights Law* (Oxford, Oxford University Press 2014) pp.7-9.

¹⁰⁴¹ Annabelle Mooney, *Human Right and the Body: Hidden in Plain Sight* (Oxon, Routledge 2014) pp.4-5.

with the utility to human being within the realities of their daily life.¹⁰⁴² In order to migrate from the abstract nature of human rights, the everyday life of an individual is only meaningful when analysed within their values, morals and choices, which evolve with decades of experience. Mooney recognises that the ideologies of individualised freedom and equality have progressed in terms of rhetoric; however, practical actualisation of rights can no longer remain within a restricted arena without multifactorial interactions within legal, political and cultural institutions. Hoffman and Rowe however note that there are possibilities of limitation in practice, especially concerning issues in direct disagreement with other individuals.¹⁰⁴³ In other words, consideration must be given to what is in the best interest or benefit of the entire community.¹⁰⁴⁴

Based on the core principles of the UDHR, various other charters and declarations on human rights protection have emerged. Prominent amongst the charters is the European Convention on Human Rights 1950 (ECHR). The Council of Europe enacted the ECHR in 1949 at the end of the Second World War which was designed to protect “human rights of peoples in countries that belong to the Council of Europe”.¹⁰⁴⁵ Articles of the ECHR provide for the safeguard of basic human rights without the encroachment from institutions, government or persons.¹⁰⁴⁶ Core focus of all human conventional language rests on the narrative that all men were created equal¹⁰⁴⁷ and therefore should be accorded same opportunities to express their

¹⁰⁴² *Ibid.*

¹⁰⁴³ David Hoffman and John Rowe, *Human Rights in the UK: An Introduction to the Human Rights Act 1998* (Harlow, Pearson Education Limited 2013) p.12.

¹⁰⁴⁴ *Ibid.*

¹⁰⁴⁵ Equality and Human Rights Commission available at <https://www.equalityhumanrights.com/en/what-european-convention-human-rights> [accessed 10th April, 2019].

¹⁰⁴⁶ *Ibid.*

¹⁰⁴⁷ Carpenter, *op. cit.*

individualised freedoms without fear of reprimand or oppression. The United Kingdom domesticated the ECHR by enacting the HRA.¹⁰⁴⁸ Prior to the HRA, there was no conventional method for articulating the apposite human rights protection for individuals within the UK jurisdiction.¹⁰⁴⁹ Hoffman and Rowe considered the HRA as “one of the most important statute ever passed in the United Kingdom”, as the HRA provided a legal framework to ensure the enforceability of fundamental freedoms and entitlements.¹⁰⁵⁰ The HRA sets out the European Convention Rights, which were ratified and integrated into the UK law,¹⁰⁵¹ enabling the projection of a new viewpoint on the individuality of citizens within the United Kingdom.¹⁰⁵² The HRA articulates precisely the basic rights that must be accorded respect by the UK Parliament and thus is relevant to past, present and future enactments by the Parliament.¹⁰⁵³ Human rights are fundamentally based on the moral nature of being human hence the intertwined connotation of living a well-meaning life of dignity, self-worth and self-respect.¹⁰⁵⁴ The policy paper on the ‘*Human Rights Bill: Rights Brought Home*’ presented to the Parliament by the Secretary of State for the Home Department explained in detail the underlying significance of ensuring that the convention rights were easily obtainable to the people.¹⁰⁵⁵ According to Tony Blair, the HRA presents the individuals in the United Kingdom with a speedy and efficient method of implementing the ECHR in English courts.¹⁰⁵⁶ The HRA ultimately

¹⁰⁴⁸ *Ibid.*

¹⁰⁴⁹ Hoffman and Rowe, *op. cit.* p.16.

¹⁰⁵⁰ *Ibid.*, p.1.

¹⁰⁵¹ Robert Reed and Jim Murdoch, *Reed and Murdoch: Human Rights Law in Scotland* (West Sussex, Bloomsbury Professional Plc 2017) pp.15-16.

¹⁰⁵² Hoffman and Rowe, *op. cit.*, p.1.

¹⁰⁵³ David Hoffman and John Rowe, *Human Rights in the UK: An Introduction to the Human Rights Act 1998* (Harlow, Pearson Education Limited 2013).

¹⁰⁵⁴ Donnelly, *op. cit.*, p.1.

¹⁰⁵⁵ Human Rights Bill: Rights Brought Home [Cm 3782] available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263526/rights.pdf [accessed 20th June 2019).

¹⁰⁵⁶ *Ibid.*

resonates a consciousness thereby ensuring that the human rights of the people are a priority in making foreign policy decisions.¹⁰⁵⁷ The HRA therefore represented a commitment to the adherence and satisfaction of the rights and fundamental freedoms guaranteed under the ECHR.¹⁰⁵⁸ It became imperative that the UK courts and tribunals must then take the decisions, judgments and advisory opinions of the European court in deciding questions regarding the rights entrenched under the ECHR.¹⁰⁵⁹ This development spearheaded the shift of focus from the duties entrusted on public authorities to the rights available for individuals to claim under the HRA. The implication is that individuals can then exercise liberty in challenging actions that constitute a breach of their protected human rights by bringing “proceedings against the authority under this act in the appropriate court or tribunal, or rely on the convention right or rights concerned in any legal proceedings”.¹⁰⁶⁰ Section 6(1) created an accountability mechanism in fulfilling those rights. Emphasis rested on the law courts, tribunal or person vested with public function to “act in a way “incompatible with the convention rights”.¹⁰⁶¹ Court declarations relying on the ECHR rights could provide the anticipated clarity or paradigm shift on the practice of human rights within healthcare law.¹⁰⁶²

However, ratified conventions and domestic law remain static and unreflective to the physical, mental and psychological needs of the common man. Although the UDHR states that the “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and

¹⁰⁵⁷ *Ibid.*, p.1.

¹⁰⁵⁸ HRA 1998, s.1 (1)(5) available at <http://www.legislation.gov.uk/ukpga/1998/42/schedule/1> [accessed 22th August 2019].

¹⁰⁵⁹ HRA 1998, s. 2(a).

¹⁰⁶⁰ HRA 1998, s. 7 (1) (a-b).

¹⁰⁶¹ HRA 1998, s. 6(1).

¹⁰⁶² Maclean, *op. cit.*, p.185.

peace in the world”,¹⁰⁶³ the real existence has failed to reach those “small places, close to home - so close and so small that they cannot be seen on any maps of the world”.¹⁰⁶⁴ The vision of progress in the existence of mankind is not justified by how well the enactments in the conventions and treaties are worded but in the practicality of individual situations and the ability to find legal backing in exploring those rights. For instance, a homeless child on the street with no food or water, or even basic education cannot understand that she has a right to those things. It would then be inhuman to deprive of those socio-economic and cultural rights. When rights are adjudged abstract, the connection between human existence and suffering is lost. Similarly, a person under paternalist control will not embrace her full rights and freedom of expression, dignity and worth. The human experiences are constantly altered and elaborated by the demands to stay in control. The nature of the institutions that control the human environment also advance with them, giving rise to very diverse practices. Thus, interpreting treaties, conventions and domestic rules in manners that reflect present trends and behavioral evolution of the *Homo Sapien* is inevitable. The complexity and individuality of the human nature coupled with their social, economic and cultural challenges have continuously embraced the dynamism of human rights to adapt to changes across multi-disciplinary fields. Donnelly explains that human rights should not be regarded as timeless, unconditional and non-changing. He contends that the nature of human rights is consistent with its universal nature and would historically evolve,¹⁰⁶⁵ ‘shape and reshape’¹⁰⁶⁶ based on a specific era or period.

¹⁰⁶³ United Nations, ‘Universal Declaration of Human Rights’ available at <http://www.un.org/en/universal-declaration-human-rights/> [Accessed 10th January, 2019].

¹⁰⁶⁴ Mary A. Glendon, *A World Made New: Eleanor Roosevelt and the Universal Declaration of Human Rights* (New York, Random House 2002) p. 325.

¹⁰⁶⁵ Donnelly, *op. cit.* 8.

7.2 Personhood

The underlying principles of a human rights-based approach recognises the essence and distinctiveness of a person and enabling an environment for those tangible rights to be claimed. In addition, holding institutions accountable when those rights are not respected, fulfilled or protected.¹⁰⁶⁷ In understanding the full autonomy, reasoning of what it means to fully characterise an individual as possessing bodily autonomy as a person also emerge within the medical field. Whittenberger recognises that although there may be a consensus that the understanding of human rights includes the acknowledgement that they possess fully all aspects of rights; however, the unanswered question remains, who is a person?¹⁰⁶⁸ Whittenberger notes that a person within this definition is a human adult “who is conscious, senses, thinks, feels, behaves, has preferences and values, remembers, learns, makes decisions, communicates and interacts”.¹⁰⁶⁹ Human beings existing within a preserved consciousness are able to undertake their roles by fulfilling obligations and maintaining an awareness.¹⁰⁷⁰ Capacity of consciousness is demonstrated through the barrages of awareness of experiences past and present, having shown the capability of relaying that information to the next person without ambiguity. The optimisation of rights in combination with the capacity of consciousness forms the basis for human expressions.

¹⁰⁶⁶ John Witte, *God's Joust, God's Justice: Law and Religion in the Western Tradition* (Cambridge, Eerdmans Publishing Co. 2006) p.75.

¹⁰⁶⁷ Care about Rights? *op. cit.*

¹⁰⁶⁸ Gary Whittenberger, 'Personhood and Abortion Rights: How Science Might Inform this Convention' (2018) 23(4) available at https://www.skeptic.com/reading_room/how-science-might-inform-personhood-abortion-rights/ [accessed 7th August 2019] pp. 34-39.

¹⁰⁶⁹ *Ibid.*, p.36

¹⁰⁷⁰ *Ibid.*

The concept of personhood has remained at the core of legal argument in context of right discourses, especially in creating a distinction between a person and a human being.¹⁰⁷¹ Personhood is engraved in the tenets of human rights because “it confers status, respect and moral worth”.¹⁰⁷² Although engaging the personhood of an individual is not always appropriate or fitting in every value-centred situation, the starting point is to understand a person within a system that predicts their rights and responsibilities.¹⁰⁷³ Similarly, providing a candid approach to a human being by reimagining their purpose as person rather than carefully padded myth is crucial. However Ohlin notes that there is no need to completely erase the relevance of personhood from legal reasoning especially in connection with human rights. However, there is need to seek a deeper and in-depth analyses of the position of various components to obtain a better clarity of the human rights implication¹⁰⁷⁴ The concept of person is easily implemented in a right-based framework when the dignity or bodily integrity of the person is in question. The narrative is in line with the numerous drafted conventions, which promote the individuality and liberty of all within their most natural of biological state. Adopting a right-based approach entails that the person is given the opportunity to make decisions that impact their rights in a way that integrates and upholds their individual conviction. More so, in combining the transcending values and morals inherent in the person, an empowering and liberating construct of the personhood emerges. Translating this to individuals who are medically adjudged to lack capacity due to their mental disorder, the challenges are lessened with the realisation that a person is deemed to have capacity to consent or decline involuntary treatment because they are conscious beings. The setting and

¹⁰⁷¹ Jens D. Ohlin, ‘Is the Concept of the Person Necessary for Human Rights?’ (2005) 105(209) Columbia Law Review p.211-212

¹⁰⁷² *Ibid.*, p.211.

¹⁰⁷³ *Ibid.*, p.211.

¹⁰⁷⁴ *Ibid.*, p.212.

formalities of a right-based approach necessitates a background approach in finding solutions, which enhance the sensitive shift from ‘needs to rights’ and ‘clarity to focus’, consistent with accountability, non-discrimination and participation.¹⁰⁷⁵ The core foundations of individualised freedoms with a human rights framework are apparent in multiple ratified treaties and conventions over the years. In instituting a rights based claim, the concept of an individual as a dignified person who can actualise their choices and decisions regardless of the legal discourse in play emerges. Invariably for the concept of person to uphold within the tenets of human rights, a systematic difference between the person as owning their own identity and the human being is made.

An in-depth definition of a person can be examined with consideration to their needs, desires and decisions. The challenge is on how to create visibility and interpret these values in a ways that can be recognised by third party decision makers. The anorexic body is established as multifaceted, diverse and complex and therefore presents different facets when faced with other scenarios. A displacement of their control in ways that demonstrates incapacity leaves a significant impact on their freedoms. It is therefore a challenge to ordinarily or automatically deconstruct all conscious or unconscious reasoning of behaviour without their free will in play. The interplay between their choices and decisions enables the individual the freedom to take a positive or negative stand in accepting or refusing decisions affecting their dignity or integrity. Analysing human beings and the values of freedom, del Russo recognises that:

¹⁰⁷⁵ Peter Uvin, ‘From the Right to Development to the Rights-Based Approach: How “Human Rights Entered Development’ in Andrea Cornwall and Deborah Eade, (eds.) *Deconstructing Development Discourse: Buzzwords and Fuzz* (Warwickshire, Practical Action Publishing 2010) p.170.

“Man has indeed individual basic needs, inherent to his human nature, as a human being he needs to live life in freedom, to sustain it, to perpetuate it physically and spiritually. The enjoyment of these freedoms is for all human beings the essential condition for a life worthy of its name; without them man ceases to exist as such. Man’s pursuit of happiness is the achievement of self-expression in freedom under the aegis of law.”¹⁰⁷⁶

Reflecting on the historical observations of the struggle to embrace individual actions of freedom, there is awareness that third party choices do not interfere or restrict the freedom of others. Yet, the great negative commandment ‘[t]hou shalt not allow any man to interfere with the liberty of any other man’ still sits in the abstract corridors of reality.¹⁰⁷⁷ Most persons embrace the values and choices they choose and flourish in the knowledge and existence of those ideals. However, by normalizing these behavioural patterns, legitimate concerns emanate from the claims, which do not fit within a legitimised system. There are considerable constraints for granting unlimited freedom for the advancement of personhood outside the capacity test. Relatively, an incoherent grasp at the chances of securing a threshold of rights whether admissible or not gives rise to substantive identity crises. The challenge in advancing self-expression is created by third party interventions with the objective of monitoring, controlling and influencing how a person’s freedom is expressed. Human existence, progression and evolution are evaluated by individualised autonomous actions indicative of

¹⁰⁷⁶ Alessandra L. Del Russo, *International Protection of Human Rights* (Washington, Learner Law Book Co. 1971) pp.254-255.

¹⁰⁷⁷ Leonard Huxley, *Life and Letters of Thomas Henry Huxley* (New York, Cambridge University Press 2012) p.53.

choices and decision unorthodox to social genre. The purest form of bodily existence is a valued autonomous state constructed outside the boundaries of bodily slavery.

Sen using a bike ride example equated the 'state of being' to the ability to function intentionally and independently without any aid or influence.¹⁰⁷⁸ Sen recognised that self-fulfilment and expressing real autonomous emotive capabilities is essential to the way a human being lives, acts, be or do.¹⁰⁷⁹ The objection to the margins of third party interaction is remarkable and coincides with the underling mental emancipation. Significantly translating a wish, choice or moral into a legal claim will demand an endless attempt to defer the already established pattern resolving similar issues. In asserting personhood, individual entitlement will conflict with structural strategies of human rights. Understandably, there are personal interests focused on less practical enforcement mechanisms. Those choices can only be valuable if they are autonomous choices with the ideals of equality, justice and freedom. Similarly, Nussbaum acknowledges the correlation between human rights and human capabilities. The intention is to provide an unorthodox method for enjoying human rights within a system that can respect the individual differences and preference.¹⁰⁸⁰ Nussbaum argues that individual functions can only be communicated in its true human form, which entails freedom to exert human powers in self-expressive and creative means. Tangible focus should be placed on the individuality of a person including themes and patterns that they are evolving.¹⁰⁸¹ Inability to perform such functions that express human individuality freely is inhuman and animalistic and devalues people's

¹⁰⁷⁸ Chad Kleist, *Global Ethics: Capabilities Approach* available at <http://www.iep.utm.edu/ge-capab/> [accessed 11th February, 2019].

¹⁰⁷⁹ Amartya Sen, *Commodities and Capabilities* (India, Oxford University Press 1999) p.17.

¹⁰⁸⁰ Martha C. Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge, Cambridge University Press 2000) p.96.

¹⁰⁸¹ Martha C. Nussbaum, *Creating Capabilities: The Human Development* (Cambridge, The Belknap Press of Harvard University Press 2011) pp.69-72.

autonomy. A crucial part to fulfilling these central capabilities encompasses the respect for bodily integrity. As pointed out by Nussbaum, bodily integrity is the ability to move around freely, along with total dominance and control over their body.

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Prior to acknowledging human rights, people existed as just humans. They were just beings with a genetic formula. “Humans have bodies”.¹⁰⁸³ The body DNA is the unique blueprint of every part of life, comprising of thousands of proteins built and organized to function independently. Humans exist because of the integrated body inclusive of trillions of cells, organs and collection of compound tissues. Humans only function because of the interaction within this body of systems.¹⁰⁸⁴ As humanity continuously progresses, it becomes more apparent that human beings portray more unconventional individuality to any form of interference or control. It is possible to accept that freedom bestowed on the human body is controlled in many forms by the government, medical practitioners and, in most instances, the family. Individual freedoms are restricted despite individual choices. In the haze of the numerous angles for claiming rights, it becomes evident that there is deviance in the subjectivity of control and restriction of freedom. In a similar context, feminist resilient fights for the protection of reproductive rights as opposed to reproductive control.

The basis for most accounts focuses on sexual reproductive rights overlooking the personhood. As such, it is not surprising that abortion rights have drawn mainstream debates on themes for pro-life and pro-choice without underpinning the struggle

¹⁰⁸² Kleist, *op. cit.*

¹⁰⁸³ Mooney, *op. cit.* p.3.

¹⁰⁸⁴ Alice Roberts, *Human Anatomy: The Definitive Visual Guide* (London, Dorling Kindersley 2014) pp. 2-3.

outside the firm ideology of both legal and social inequalities of reproduction control. Restricting or controlling a unique component of the individual undermines the boundaries and weakens their autonomy. It is misleading to center arguments solely on women rights as basis to affirm or deny pro-life or pro-choice. According to Bordo, evidence reveals traditional patterns of reproductive control as an assault on the woman's personhood.¹⁰⁸⁵ In some instances, personhood is equated to the metaphors of human existence and the highlight of the interaction to the human physical body.¹⁰⁸⁶ This reciprocal action becomes a reflection of their unique embodiment and integrity. The way a person feels or interacts with their body equates with their values, morals and choices, setting and observing the limits to being an actual person.

Personhood has been extensively acknowledged as a valid tool for human rights assertion.¹⁰⁸⁷ Existing rights concepts are not totally opposed to the underlying basis for expressing a unique consciousness as a person. In most liberal traditions, it defines the recognition of the essence of the individual as well as their capability. For instance, constructing a functional recognized exercise for the anorexic body will produce a standard cognizance unique to the individual. Experiences are effective and efficient criteria in a logical communication of their personhood. Capacity in personhood is often stereotyped and held at dual standard, playing both sides of encroachment on the values of human existence. Immanuel Kant presented a critical view on rationality and reasoning as a key to personhood. A person must possess the ability to make autonomous decisions and present those facts in a manner

¹⁰⁸⁵ Bordo, *op. cit.*, p. 73.

¹⁰⁸⁶ Alzheimer Europe, 'Personhood: Other Ethical Principles' available at <http://www.alzheimer-europe.org/Ethics/Definitions-and-approaches/Other-ethical-principles/Personhood> [accessed 9th April 2019].

¹⁰⁸⁷ *Ibid.*

comprehensible to others. Kantian ethics provided a model between the interception of humanity and the reality of self as the essence of cultivating personhood.¹⁰⁸⁸ A similar shift suggests that the natural cause of both male and female are dissimilar and in order to satisfy humanity, rational capacities must be applied alongside autonomous actions.¹⁰⁸⁹ According to Marwah, Kant's views on the natures of men and women (gendered moral agency) in the context of humanity have been regarded as 'inconsistent and morally ambiguous'.¹⁰⁹⁰ More problematic is the understanding of character and virtue articulated in systems of gender-based singularities, strictly in either empirical or moral sense.¹⁰⁹¹ For some theorists, Kant's personhood is controversial and 'essentially a contested concept.

An unambiguous definition of personhood depends on the recognition of moral and legal rights a person holds facilitating a background for self-control and free will. There is an organic symmetry between the physical appearance of a person and their mental aspects without giving into fundamental constituents of theories of reductionism or Cartesian dualism. The moral, social and political assumptions on personhood have been an active subject of debate in modern history. The vagueness surrounding the term 'person' and what it means to be a person has fostered deliberation amongst philosophers, theorists and political activists. In hindsight, if everyone enjoyed the equality of treatment and respect for dignity guaranteed by numerous treaties and conventions, the debate on the concept of personhood will not exist. It is difficult to abstract a person from the principles and morals that govern the way a person behaves or chooses to conduct themselves or their wellbeing. Merrill

¹⁰⁸⁸ *Ibid.*

¹⁰⁸⁹ Inder S. Marwah, 'What Nature Makes of Her: Kant's Gendered Metaphysics' (2013). 28(3) *Hypatia Journal* pp. 552-554.

¹⁰⁹⁰ *Ibid.*, p.553.

¹⁰⁹¹ *Ibid.*, p.554.

argues in favor of a new approach from an “actual people” perspective submerged in human practices, which excludes arbitrary language.¹⁰⁹² This means identifying exclusively with the “ultimate personalization of reality. Thus, there is recognition of the intrinsic features a person identifies and attaches to the reality of their experience in all circumstances. There is emphasis on the moral decisions made by third parties to be inclusive of “a person’s ethics, manners, character and what they believe is proper behaviour”.¹⁰⁹³ A rights approach is aligned with the notions that establishes the uniqueness of a person’s ethical status and demands respect for a person’s choices and actions in clinical and public settings.¹⁰⁹⁴

The rights approach in the treatment and care of the anorexic body has never been deeply explored. The critical questions then center on the legal and ethical implications of various invasive treatment options as well as a person’s right to bodily integrity and freedom from subjection to treatments they consider degrading on any level. The human body has become a preoccupation of society, the changes they undergo physically, emotionally and mentally are often subjected to dissections, speculations and, to great extent, assumptions. Strict interpretation of the right to life has fostered and engaged the “doctors knows best” ideologies, to the detriment of preserving personal autonomy. Prolific cases of persons who voluntarily succumb to self-starvation as a way of self-rule¹⁰⁹⁵ reveal the critical struggle by healthcare practitioners to preserve life while at the same time respect the personhood.¹⁰⁹⁶ Critics of involuntary treatments of the anorexic body insist that unconsented treatments

¹⁰⁹² Sarah B. Merrill, *Defining Personhood: Toward the Ethics of Quality in Clinical Care* (Amsterdam-Atlanta, Editions Rodopi BV1998) pp. 4. 5.

¹⁰⁹³ *Ibid.*

¹⁰⁹⁴ *Ibid*

¹⁰⁹⁵ Keywood, *op. cit.*, p. 604.

¹⁰⁹⁶ Joseph P. Murphy, and William Dunn, ‘Transparency in Health Care: An Issue throughout US History’, (2008) 133(1) Chest Journal p.9.

infringe on the dignity,¹⁰⁹⁷ bodily integrity, and autonomy of a person.¹⁰⁹⁸ Applicable methods such as forced tube feeding and unconsented detentions necessitate more transparency and inclusion by healthcare practitioners in administering their duty of care.¹⁰⁹⁹ Medical law expert, Dubrow, rightly points out that the era of ‘the doctor knows best’ and absolute paternalism is long gone.¹¹⁰⁰ Foucauldian literature now influences contemporary thinkers to objectify the effects of unwanted action on the body.¹¹⁰¹ Ideally, compulsory patients can become voluntary patients by incorporating the decisions, morals, choices and autonomous values into treatment decisions. It is, therefore, impossible not to echo the same sentiments of Silber J, who insists that transparency and autonomy should trump any ethical considerations.¹¹⁰²

7.3 The Right to Refuse Involuntary Treatment.

The typical anorexic body is predominantly female and unquestionably complex. The only means of meaningfully dissecting and understanding the complexity is to acknowledge and emphasize their individualised or person-centered view. Western literature contends that the biological consequences to assuming the status of an anorexic body might be grave for some,¹¹⁰³ however for the meaning centered

¹⁰⁹⁷ Tracy L. Irvin, ‘Legal, Ethical and Clinical Implications of Prescribing Involuntary, Life-Threatening Treatment: The Case of the Sunshine Kid’ (2003) 48(4) *Journal of Forensic Science* p. 858.

¹⁰⁹⁸ Romuald Brunner, Peter Parzer, and F. Resch. ‘Involuntary Hospitalization of Patients with Anorexia Nervosa: Clinical Issues and Empirical Findings’ (2005) 73(1) *Fortschr Neurol Psychiatry Journal* p. 9.

¹⁰⁹⁹ Penny Lewis, ‘Feeding Anorexia Patients who Refuse Food’ (1999) 7(1) *Medical Law Review* p. 23.

¹¹⁰⁰ Dimitra Dubrow, ‘Gone Are the Days of ‘Doctor Knows Best’ (2016) available at <http://neoskosmos.com/news/en/Gone-are-the-days-of-doctor-knows-best> [accessed 15th May 2018].

¹¹⁰¹ Deveau, *op. cit.*, pp. 223–247.

¹¹⁰² Silber, *op. cit.*, pp. 284–285.

¹¹⁰³ Evelyn Attia and Timothy Walsh, ‘Treatment in Psychiatry: Anorexia Nervosa’ (2007) *The American Journal of Psychiatry* p.1806.

anorexic body, they can lead a normal life especially as conscious death or suicide is never the objective. Food resistance and hostility to ingesting food provide an insight into core versatility of the individual experiences existing in different forms. Their abnormal behavior and experiences are classically different from the treatment professional's one-dimensional views of anorexia. It is evident that there is margin in the pattern of behavior and aspirations of the patient centered anorexic body (suicidal) and the meaning centered. The nature of approach by law and medicine is yet to reflect this outcome and show sensitivity to a group of individuals who are conscious of the way their bodies are historically monitored, micro-managed and involuntarily treated.

Mooney recognises that the body has been forgotten as a vessel of expression, which cannot be side stepped.¹¹⁰⁴ Bordo acknowledges that the problem lies in the way western culture identifies the female body as primitive and unrestrained without reflecting on the body in terms of responsibility and meaning.¹¹⁰⁵ The body is informed by our history and represents the subjective struggle to maintain dominance over its affairs.¹¹⁰⁶ The implication is the values that represent the female body can only advance beyond contemporary situations insofar there is fulfilment of their rights and freedom. The universal condition of the human body is therefore a reflection of the state of human rights.¹¹⁰⁷ The interpretation of human nature is fluid and built on an ever-changing socio-cultural dynamics that make up their needs. Most human needs, wants and desires are complex and on the surface level and do not interact with static behavioral constructions of the society. Regardless, in the growing

¹¹⁰⁴ Mooney, *op. cit.*, p.2.

¹¹⁰⁵ Bordo, *op. cit.* p.13.

¹¹⁰⁶ *Ibid.*, p.13.

¹¹⁰⁷ Mooney, *op. cit.*

multifactorial demands of human nature, the boundaries of human rights protection must be expanded to accommodate unconventional practices and actions of a person.

The meaning centred anorexic body represents the critical dimensions of a non-static construction in provoking a new meaningful way of thinking. Knowing how the meaning centred anorexic body interacts with food intensifies the validity of the contradictory values of the dominating factors that regulate human behaviors. For the anorexic body, the implication of food refusal is more intense and varied than clinical pathology. The anorexics disassociations with food are not only inherently built on adjacent values but also on the peculiarities of the freedom they express. The body therefore goes beyond its association with food or calorific intake but represents a broader creation of femininity. The meaningful nature of their resistance to the overwhelming knowledge of what food represents as an object of coercion and involuntary treatment. Meaningful approach to food consumption is opposed to the lauding of food to solely represent substance for preserving life and by extension welfare protection for clinicians. Non-meaning approach to food maybe valid for a different type of person depending on the direction of analysis and for what purpose the outcome represents. Wicks analyses the challenges of a pregnant anorexic woman and notes that it has become evident that the UK medical profession and the court of law may have inadvertently developed a discriminatory attitude shown in their eagerness to establish the incapability of women to make decisions of what to do with their body.¹¹⁰⁸ The danger is that the system is set up to adjudge incompetence based on refusal of medical treatment.

¹¹⁰⁸ Wicks, *op. cit.* p.38

The general classification of persons who stay away from the general knowledge of food and what it represents definitely is problematic whether the issues of competency arises or not. Mental health laws have enabled critical accounts and views of the body in a way that equals self-starvation with poor mental health. Suffice to say, the biological human being is portrayed as suffering thereby requiring precise treatment, which is administered with consent. The narrative of anorexics as mentally disordered beings often reveals their vulnerability therefore needing care and treatment.¹¹⁰⁹ However, autonomy and freedom of choice are reduced to a substantive degree thereby trampling on their rights. The most critical false dimensions have further equated seeking the right to refuse involuntary treatment as same as seeking the right to die. The right to refuse to be treated involuntarily does not constitute equate seeking to die. Concisely, the tenets of exercising the right to refuse involuntary treatment interlink with safeguarding autonomy, preserving dignity and conserving bodily integrity. Within a wider margin of claim, there is also the interpretation of participation in decision-making and procuring consent. Wick therefore states that the right to refuse involuntary treatment is reflected in multiple conventions rights.¹¹¹⁰ Article 2 of the ECHR provides for the legal protection of the right to life.¹¹¹¹ This position was also reiterated in *Re E (medical treatment: Anorexia)* where the court held that “all human life is of value and so therefore, a presumption will always exist in favour of preserving human life.”¹¹¹²

Ironically, general reference to anorexia existing in different unique variations has been alluded to over time. Distinguishable traits included both physical status,

¹¹⁰⁹ Douzenis et al, *op. cit.*

¹¹¹⁰ Wicks, *op. cit.* p.40.

¹¹¹¹ ECHR, Article 2 available at https://www.echr.coe.int/Documents/Convention_ENG.pdf [accessed 5th December 2018].

¹¹¹² In *Re E (medical treatment: Anorexia)* [2012] EWHC 1639.

behavioral components and, to a great extent, experience. The mental health law does not specifically acknowledge this type of variation; however through empirical analysis and the study of the changing patterns of the anorexic behaviour a meaning centred variation emerges. Variations of individuals who embrace the concept of self-starvation were systematically reviewed in both historical and cultural contexts prior to the formal documented medical analysis outcomes published in the 19th century.¹¹¹³ There have been prior references to existence of a group of young individuals living in a state of emaciation. Clinicians however continue to reject the significant and conscious role individuals play in accepting the anorexic experience; instead they argued that resistance was part of the psychological mirage to conceal the mental illness.¹¹¹⁴ The degenerating role of psychiatry became evident, as anorexia assumed the symbolic hallmark of extreme disorders interconnected with insanity and neurosis.¹¹¹⁵ Crisp also alleges that all anorexics possess diminished rights of independence and exhibit immaturity in leading a normalized life.¹¹¹⁶ Crisp's analysis also fails to accommodate the conceptual controlled starvation model that does not lead to complete shutdown of the human anatomy. Insisting on a physical detection of anorexia generates the presumption treatment professionals require to reinforce incapacity based on circumstantial evidence. Thus, they tackle the anorexic body as a patient without addressing the underlying issues intertwined with their experiences and, largely, personal distress. Families and close relations are then compelled by societal and social pressures to approach clinical or care professionals to aid physical recovery. This becomes very challenging to the anorexic body that more often than

¹¹¹³ J.R. Bemporad, 'Self-Starvation through the Ages: Reflections on the Pre-History of Anorexia Nervosa' (1996) 19(3) International Journal of Eating Disorder p. 217.

¹¹¹⁴ Crisp, *op. cit.*, p.4.

¹¹¹⁴ *Ibid.*, p.3.

¹¹¹⁵ *Ibid.*, p.4.

¹¹¹⁶ *Ibid.*, p.14.

not they choose to be disengaged from any form of treatment provided by health care professionals. Once resistance is registered, the implication on the health care practitioners, the anorexic body and their families becomes visible. The reluctance to follow through with treatment will also compound the complex capacity test, and so not in favor of the anorexic body. This is because the stereotype of treatment refusal is a profound indication of incapacity regardless that the person is functional in memory, can reasonably communicate and aware of their advanced directive. There are far reaching debates on the issue questioning labeling concepts or conditions unfamiliar to the understanding of the society.¹¹¹⁷ The nature of care and management, if at all necessary, should reflect the sensitivity of individuals to the way their bodies have been historically monitored, micro managed and treated involuntarily. The only way an anorexic body is denied the right to stay as she is and lead an independent life is by imposed involuntary treatment procedures as well as a disengagement from the control of her weight. It is important to note that case studies indicate that efforts to “disengage the anorectic conceptually from domination of her body weight, does not by any means succeed.”¹¹¹⁸

The prominent and progressive feature of a meaning-centered anorexic body reflects a person leading or showing intent to lead a conceptually normal life within a controlled weight devoid of any attempt to end their life. In *A Local Authority v E*.¹¹¹⁹ It is evident that *E* a 32-year old displayed no core attributes of the meaning-centered anorexic body. This is because *E* was able to complete her college studies and enrol into a university to study medicine and excelled in this highly demanding course

¹¹¹⁷ Louise M. Murray and Suzanne Boyd ‘Protecting Personhood and Achieving Quality of Life for Older Adults with Dementia in the U.S. Health Care System’ (2009) 21(2) Journal of Aging Health 350-373.

¹¹¹⁸ Crisp. *op. cit*, p.147.

¹¹¹⁹ *A Local Authority v E*. [2012] EWHC 1639 (COP).

despite living within a controlled weight. However, although described as ‘highly intelligent and articulate’, *E* had no desire to continue life and attempted suicide multiple times. Other issues were cumulative to *E*’s compulsory admission under the Mental Health Act. Dr Tyrone Glover explains that in addition to her eating disorder, *E* also suffers from unstable personality disorder, prescription drugs dependency (opiate) and alcoholism.¹¹²⁰ In July 2011, *E* signed the first advanced decision preventing anyone subjecting her to any life sustaining treatment. The advanced decision stated, “ I do not want to be resuscitated or given any medical intervention to prolong my life.”¹¹²¹ *E*’s continuous suicide attempts by hanging and lack of desire to live automatically places *E* as a patient centred anorexic body, which ultimately contributed to the court’s decision reinforcing involuntary treatment.

The case of *E* in *NHS v E* can be contrasted with *NHS v L*. were Ms L, a 29-year old intelligent anorexic body¹¹²² who continuously informed her family of her willingness to continue to live and not die but preferred to exist on a specific body mass index and adhering to a restricted calorific intake.¹¹²³ The significance of Ms L’s effort to continue to live was in her voluntary consent to receiving only 25ml per hour of nutrients by nasogastric tube. Judge Eleanor also acknowledged that L, although indifferent, was very conscious and rational in making her decisions which included accepting the administration of analgesia and antibiotic treatments for the infections that would have otherwise led to her demise.¹¹²⁴ In addition to making plans for the future, L’s desire to continue to live was also evidenced in her 2012 quest to move to

¹¹²⁰ Ibid., para. 23.

¹¹²¹ Ibid., 57.

¹¹²² *NHS v L & Others* [2012] EWHC 2741 (COP).

¹¹²³ Ibid.

¹¹²⁴ Ibid., para.54.

a nursing home but became greatly distressed when her bed was withdrawn.¹¹²⁵ The Judge also noted that L was sensible and lucid and is only overwhelmed by the “terror of gaining weight and the fear of calorie”.¹¹²⁶ Although L’s desire to continue to live was recognized, the Judge failed to acknowledge the possibility that her life might be overwhelmed by the protracted invasion of her body without her consent. On numerous occasions, she had been involuntarily treated and forcibly fed against her wishes. It is also unclear as to why L was deemed rational and possessing capacity to accept antibiotic treatment to heal her sore and irrational and lacking capacity to exist within the body weight she deems necessary without the prejudice. Recognizing an individual as a rational agent justifies their actions and the choices they choose to make.¹¹²⁷ It has previously been argued that the right thing to do is what an individual chooses to do, the right they have to express themselves freely, which appeals to Kantian ideologies of “justice to each persons will”.¹¹²⁸ It sometimes does not hinge on good or bad but on what an individual purports to be in their best interest.¹¹²⁹ Applying human rights-based approach recognizes the free will and individuality of the anorexic body ensuring that they are the principal decision makers in outcomes that affect their state of existence. This approach will require that individuals be given the opportunity to claim whilst holding institutions accountable when those rights are not respected, fulfilled and protected.

The behavioural patterns of the anorexic body are at the core meaning centred, conceptualised in the realisation that the person can exercise their autonomy as a

¹¹²⁵ *Ibid.*, para. 35.

¹¹²⁶ *Ibid.*, para 59.

¹¹²⁷ Garrath A. Williams, ‘Praise and Blame’ available at www.iep.utm.edu/praise/ [Accessed 2nd August 2018].

¹¹²⁸ *Ibid.*

¹¹²⁹ *Ibid.*

rights bearer existing outside the standard medical stereotypical classification. The idea that human rights consideration should precede medical treatment, in addition to further contemplation of inclusion of individuals as active participants in decision making is relatively outside the norm in treating the anorexic body. In some cases, the medical practice route only envisions a system where individuals are expected to accept all medical directives as far as part or full recovery can be achieved. For instance, regardless of the individual's choices and directive, imposed involuntary treatment methods is deemed absolute necessity in managing and treating anorexia nervosa. Once anorexia nervosa is established, regardless of whether capacity is proven or otherwise, the mental health of the individual is questioned and tested. The principle of obtaining informed consent is also second tiered or negated in favor of establishing *prima facie* the incompetence and incapacity of the individual to participate and engage in decisions that ultimately affect and alter their life. The meaning centred variation introduces a balanced dimension in medical treatment or care, which recognizes a level of consciousness of obvious decisions and choices on the way the body changes or develops. The right-based approach is therefore grounded on the ability of an individual to be autonomous, free from interference and respect for the instinct values of their personhood.¹¹³⁰ The obligation for clinicians in this instance becomes evident to respect the values of their choices and decisions without compulsion or coercion. There are acceptable standards regarding how to relate with an individual who is a non-patient at the time of initial evaluation.¹¹³¹

Where involuntary treatments are suggested for the meaning centred anorexic body, the interest of doctor is aligned the interpretation of Article 2 of the ECHR.

¹¹³⁰ Douglas P Olsen, 'Influence and Coercion: Relational and Right-Based Ethical Approaches to Forced Psychiatric Treatment', (2003) 10(6) *Journal of Psychiatric and Mental Nursing* pp.16-22.

¹¹³¹ *Ibid.*

Preserving the ethics of the medical profession by not assisting a person die and lengthening life becomes sinuous. Medical interpretations of Article 2 of the ECHR raises arguments within the reasoning that refusing treatment is equivalent to the encroachment of the right to life. Equating consent refusal to involuntary treatment means that the individual intends to die either through self-harm or by third party actions in cases of assisted suicide. The meaning centred anorexic presents no intention of self-harm or suicide or any further actions suggesting the need to fulfil the requirement of death. In *NHS v X*, X an anorexic body repeatedly affirmed her wish to keep living despite the extreme thinness of the physical body.¹¹³² Wicks was also very clear on the implication of seeking active euthanasia (right to die) which signifies an on-going will to occasion death.¹¹³³ The key dimension is that there is an intentional and active pathway to self-harm, which the person is protected against. For both active and passive euthanasia, the key element is the third party who hastens the process of dying by withholding life-saving treatment.¹¹³⁴ Without third party involvement in occasioning the death of the anorexic body, the ideals of the meaning centred anorexic body lends towards having the autonomy to accept or reject any re-feeding therapeutic relief rather than procuring to die.

Salako condensed individual's rights to autonomy to include "self-determination, the right to privacy, liberty right, and the right to be let alone".¹¹³⁵ Disregard of strict autonomous principles and rules of consent are therefore agonized as remarkably submerged in paternalism to the detriment of rights protection. Salako asserts that the justification for the privileged reasoning of treatment professional should not

¹¹³² *NHS v X*, *op. cit.*

¹¹³³ Wicks, *op. cit.*

¹¹³⁴ *Ibid.*

¹¹³⁵ S.E. Salako, 'Book Review: Medical Law and Ethics' (2003) available at <https://academic.oup.com/bja/article/90/3/407/251994/Medical-Law-and-Ethics> [accessed 2nd February 2019].

reinforce unconsented approaches, which infringe on the right of autonomy under Article 8 of the ECHR.¹¹³⁶ Historically, the expertise of medical practitioners is relied on for absolute decision making to determine the type and duration of treatment or care an individual receives. The UK courts are constantly under scrutiny and are accused of being extremely submissive and compliant with the directions and dictates of the medical profession.¹¹³⁷ The ‘*Doctor knows best*’ ideologies capture this preferential treatment accorded to the medical profession. This medical strong-armed approach has often placed sole decision within the restrictive core hand of a few without considering the anorexic’s rights. Understandably, the court seem to have developed a symbiotic relationship with the medical field relying on its clarity, beneficence and expertise. In return, there is a reluctance by the courts to discard this sound opinions of esteemed professionals regardless of whether they reflect the underlying core values of consent, respect, dignity and autonomy.¹¹³⁸ Consent in medical treatment centers on reinforcing individualism and upholding the “ethical principles of respect for persons that regard individuals as autonomous agents.”¹¹³⁹ Gostin argued that the acceptance of informed consent by human rights law and international ethical codes is indicative of the crucial importance of upholding autonomous rights, as “morally necessary method of demonstrating genuine respect for human integrity”.¹¹⁴⁰ A real recognition that every person possesses inherent beliefs and values aligned with asserting their human rights will therefore enhance the necessity for treatment professionals to ensure consent is genuinely given without third party persuasion, coercion, influence or control. According to Amnesty

¹¹³⁶ *Ibid.*

¹¹³⁷ *Ibid.*

¹¹³⁸ *Ibid.*

¹¹³⁹ Lawrence O. Gostin, ‘Informed Consent, Cultural Sensitivity, and Respect for Persons’ (1995) 274(10) JAMA p.844.

¹¹⁴⁰ *Ibid.*

International, it is basic human rights for one to be able to make decisive decisions about their health, body without the fear of control by their immediate families, medical professionals and the state.¹¹⁴¹

The bedrock of modern medicine is built on the foundation that recognizes informed consent as a prerequisite to all medical procedures and investigation.¹¹⁴² The UK General Medical Council (GMC) established a general guidance to obtaining consent for healthcare professionals.¹¹⁴³ These principles of good practice applied to all both minor and major clinical intervention regardless of the magnitude or lack thereof of the risks involved.¹¹⁴⁴ The GMC principles emphasises collaborative decision making to ensure the best outcome for the individual.¹¹⁴⁵ This directive ensures that a health care professional prioritize the individual's views, value their opinion relating to their health and respecting their final choice.¹¹⁴⁶ Obtaining informed consent therefore extends to in-depth discussion of the degree of treatment to be administered including any medical analysis and projection whilst also maximizing and maintaining the autonomy the individual needs to arrive at the right decision at any given time.¹¹⁴⁷ Discussions are to focus on ensuring that the person understands all the aspects and processes of treatment, taking into account their wishes and ensuring that their rights to make adequate choices about their care is valued and respected.¹¹⁴⁸ Although the right of consent is not absolute based on assessing the relevant ethical, legal and

¹¹⁴¹ Amnesty International, 'My Body My Rights' available at <https://www.amnesty.org/en/get-involved/my-body-my-rights/> [accessed 22nd July 2019].

¹¹⁴² Christian P. Selinger, 'The Right to Consent: Is it Absolute?' (2009) 2(2) British Journal of Medicine pp.50-54.

¹¹⁴³ General Medical Council, 'Consent Guidance' available at http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_part1_principles.asp [accessed 9th May 2019].

¹¹⁴⁴ *Ibid.*, part 1, para 1.

¹¹⁴⁵ *Ibid.*, part 1, para 2.

¹¹⁴⁶ *Ibid.*, part 1, para 2 (a).

¹¹⁴⁷ *Ibid.*, part 1, para 2(b-c).

¹¹⁴⁸ *Ibid.*, part 1, para 2 (e).

practical frameworks; however initiating practical steps to ensure compliance is within an individual's right to autonomy is essential.¹¹⁴⁹ Unduly influencing or forcing another person to undertake any form of medical treatment that they have consciously refused or rejected, in the context of health care, undermines also the right to give informed consent.¹¹⁵⁰ Objectively, consent cannot be given to a procedure which the individual has rejected *ab initio* and as the prospect of approval is already a diminished likelihood.¹¹⁵¹ Selinger points out that applying and implementing the process of informed consent should therefore reflect the ethical principles of justice and fairness especially in circumstances where the “right to demand certain treatments is discussed”.¹¹⁵²

Consent to treatment centers often on individuals who had already assumed the status of a patient overlooking the need to obtain permission to conduct the physical examination and investigative process of asserting their status. During medical treatment, doctors include the freedom and capacity to engage in activities of choice to constitute consent.¹¹⁵³ A meaning centered anorexic body does not assume the status of a patient voluntarily or otherwise even whilst involuntarily hospitalized; hence the prolonged resistance to treatment and low rate of recovery once discharged. Consensual collaborations and partnership in managing the anorexic body remains essential. Thus, it is the most viable process of maintaining the level of autonomy required to ensure an open-ended level of trust and symbiotic rapport as such “each

¹¹⁴⁹ *Ibid.*

¹¹⁵⁰ Annelize Nienaber and Kirsten N. Bailey, ‘The Right to Physical Integrity and Informed Refusal: Just How Far Does a Patient’s Right to Refuse Medical Treatment Go?’ (2016) 9 (2) South African Journal of Bioethics and Law p.74.

¹¹⁵¹ Selinger, *op. cit.*

¹¹⁵² *Ibid.*

¹¹⁵³ The Crown Prosecution Service, ‘What is Consent?’ available at https://www.cps.gov.uk/sites/default/files/documents/publications/what_is_consent_v2.pdf [accessed 19th November 2018].

person has a role to play in making decisions about treatment and care”.¹¹⁵⁴ The anorexic body exists in a subdued and regimented routine expressed in day-to-day “self-surveillance and self-discipline”,¹¹⁵⁵ thus the docile body is already created. According to Pylypa, “[i]ndividuals thus voluntarily control themselves by self-imposing conformity to cultural norms through self-surveillance and self-disciplinary practices....”¹¹⁵⁶ It then follows that intrusions or interferences of the daily habitual practice without consent forces the body to respond arbitrarily.

Despite criticisms of the inadequacy of rights to find a sustainable solution to ethical issues in medical practice,¹¹⁵⁷ Pillay notes that the potency of rights based implementations has accorded ordinary people with the power to express wellbeing boundaries, assert freedom, equality and justice.¹¹⁵⁸ Right-based approach has since dominated conversations in areas of compulsions of individuals into involuntary psychiatric treatments. There is an underlying attention to acts of medical professionals which undermine the autonomy and liberty of the individual by any means including “restraint, speculation, civil commitment and forced medication”.¹¹⁵⁹ The outcry against the use of force and coercion to enforce involuntary treatments has occasioned the need for less involuntary intervention techniques. Arguments against force-feeding, which have been regarded as a form of medical treatment for anorexia nervosa, point out that the process incorporates invasive techniques of detention,

¹¹⁵⁴ GMC. *op. cit.*

¹¹⁵⁵ Jen Pylypa, ‘Power and Bodily Practice: Applying the Work of Foucault to an Anthropology of the Body’ (1998) *Arizona Anthropologist Journal* 13 available at <https://journals.uaair.arizona.edu/index.php/arizanthro/article/viewFile/18504/18155> [accessed 7th June 2019].

¹¹⁵⁶ *Ibid.*

¹¹⁵⁷ D. Benatar, ‘Bioethics and Health and Human Rights: A Critical View’ (2006) 32(1) *Journal of Medical Science* pp.17-20.

¹¹⁵⁸ Navanethem Pillay, ‘What Are Human Rights For? Three Personal Reflections’ in Daniel Moeckli, Sangeeta Shah and Sandsh Sivakumaran, (eds.) *International Human Rights Law* (Oxford, Oxford University Press 2014) pp.4-6.

¹¹⁵⁹ Olsen, *op.cit*

restraint and coercion. A rights based perspective in health care therefore embraces the notion that “moral defects of medical practice, and human life more generally, are rectified through the promotion of human rights.”¹¹⁶⁰ According to Curtice and Exworthy:

“This knowledge deficit has been recognised by government bodies and other agencies, which led to the introduction of a bottom-up human rights approach that can be used by individuals and organizations alike in everyday practice. It avoids the need to have technical knowledge of the Human Rights Act and associated case law and is based upon concepts that underpin all the articles of the Act. The human rights-based approach is the process by which human rights can be protected by adherence to underlying core values of fairness, respect, equality, dignity and autonomy, or FREDA.”¹¹⁶¹

The effectiveness of the rights approach identifies within the scope of not merely fulfilling the negative obligation of non-interference but a strong emphasis on interpreting the convention rights “in the sense which best protects the person.”¹¹⁶² This approach highlights a rather liberal stance in analysing and applying the ECHR rights in line with current social developments. Positive obligations are therefore constructed by placing the right of the individual at the forefront of all policies. Arguments in favor of the rights based approach advocated for a ‘person-centered’

¹¹⁶⁰ Benatar, *op. cit.*, pp.17-20.

¹¹⁶¹ Martin J. Curtice and Tim Exworthy, ‘FREDA: A Human Rights-Based Approach to Healthcare’ (2010) 34 *The Psychiatrist* p.150.

¹¹⁶² *Ibid.*, p.150.

health care approach built on the core principles, which acknowledge those rights and also understands that violations of those rights are unfavorable to recovery, which leads to a negative outcome. Dubrow argues that the era of ‘the doctor knows best’ are long gone.¹¹⁶³ Thus, sole decision-making based on clinical judgment has become synonymous with actions, which are regarded as not in the best interest of individuals. The House of Lords in *Bolam v Friern Hospital*¹¹⁶⁴ established the Bolam test, which requires healthcare professionals to adhere strictly to an appropriate standard and duty of care.¹¹⁶⁵ However, there is the contention that the process of creating a duty of care is less problematic than ascertaining the standard of care which again is often left to absolute clinical judgment”.¹¹⁶⁶ Understandably, clinical judgments do not include the decisions, desires, morals and choices of an individual. The accounts of individuals who decide to live a certain type of way or within a restrictive behavior are not taken into consideration in enforcing these life-altering decisions.

Clinical mechanisms for administering therapeutic reliefs on the anorexics are discriminatory in nature therefore furthering stereotypes. Since the permission or consent is not required to administer therapeutic relief, it therefore becomes irrelevant to engage with the underlying meaning of their actions. Suggestions by writers such as Crisp that anorexia can be detected by a mere glance lend validation to the stereotypical assumptions where generalized conclusions rank higher than individuals’ experiences.¹¹⁶⁷ Involuntary medical procedure contradicts consent

¹¹⁶³ Dubrow, *op. cit.*

¹¹⁶⁴ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

¹¹⁶⁵ Jones Warren, ‘Law and Ethics: The Healthcare Professionals and the Bolam Test’ (2000) 188(5) British Dental Journal p.237.

¹¹⁶⁶ Waseem Jerjes, Jaspal Mahil, and Tahwinder Upile, ‘English Law for the Surgeon II: Clinical Negligence’ (2011) Head & Neck Oncology 3(52) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3259084/> [accessed 2nd June 2019].

¹¹⁶⁷ Crisp, *op. cit.*

requirement prior to treatment thereby diminishing the freedom and autonomy to exercise some or absolute control over tangible and impactful decisions. According to NHS, consent to treatment is an established principle that validates the requirement that an individual must give their approval prior to receiving any type of medical treatment.¹¹⁶⁸ The cogency of consent has often laboriously depended on establishing that the individual has capacity to decide the outcome. Solitary reliance on the ‘capacity test’ means that clinicians do not need to obtain the consent of the individual prior to administering medical treatment or care which they believe to be in their best interest.¹¹⁶⁹ This system has often maligned the other aspects of consent, which include informed and voluntary actions devoid of any external or third party influence. The individual therefore makes sole decision after critically considering the negatives and positives of the treatment or care information presented.¹¹⁷⁰ For the meaning centred anorexic body, the issue is not reliant on obtaining consent prior to medical treatment; rather it is the requirement for treatment in the first instance. There is a difference. Delegating their autonomy to a third party to restore their body to a pre-self-starvation stage is not within the meaningful nature of their values. The meaning centred anorexic body exists within a belief system that reinforces total freedom and bodily integrity. Transferring their right to consent to third parties to undergo any type of treatment undermines their values and morals. Black therefore recognises that the jurisprudence of the right to refuse medical treatment is gradually emerging; however there is difficulty ascertaining the “class of individuals who possess the right to refuse life prolonging treatment”.¹¹⁷¹

¹¹⁶⁸ NHS, ‘Consent to Treatment’ available at <http://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Introduction.aspx> [accessed 3rd August 2018].

¹¹⁶⁹ *Ibid.*

¹¹⁷⁰ *Ibid.*

¹¹⁷¹ .Isra Black, ‘Refusing Life-Prolonging Medical Treatment and ECHR’ (2018) 38(2) Oxford Journal of Legal Studies pp. 299-327.

Article 3 of the ECHR stipulates that: “[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment”.¹¹⁷² Rights-based arguments evidently point to the method and patterns of these treatments administered to anorexic bodies without their consent. Such treatments constitute an in-depth personal invasion, which can be equated as inhuman and degrading. For instance, in *Re E*, the proposed medical treatment involved committing *E* to intensive care for a year, forceful feeding *E* via nasogastric tubes, physical restraint whilst administering treatments and the use of medical sedation when needed until *E* maintains a stable weight. The proposed treatment was also to be administered contrary to *E*’s wishes or consent.¹¹⁷³ According to the Equality and Human Rights Commission, inhuman and degrading treatments are acts which are ‘humiliating, undignified and against the innate value of all human beings’.¹¹⁷⁴ The Mental Health Act Commission in 1997 however argued that involuntarily administering food and nutrient could be regarded as a form of medical treatment. Care Quality Commission guidance on the treatment of anorexia notes that:

“In certain situations, patients with severe anorexia whose health is seriously threatened by food refusal may be subject to detention in hospital and...there are occasions when it is necessary to treat the self-imposed starvation to ensure the proper care of the patient.....nasogastric feeding can be a

¹¹⁷² ECHR, Article 3.

¹¹⁷³ In *Re E (medical treatment: Anorexia)* *op. cit.*

¹¹⁷⁴ Equality and Human Rights, ‘Article 3: Freedom from Torture and Inhuman or Degrading Treatment’ available at <https://www.equalityhumanrights.com/en/human-rights-act/article-3-freedom-torture-and-inhuman-or-degrading-treatment> [accessed 24th May 2019].

medical process, forming an integral part of the treatment for anorexia nervosa.”¹¹⁷⁵

Dovey, et al recognise that although food refusal is understood as a personal preference however professional intervention still occurs although such intervention might escalate if not handled properly.¹¹⁷⁶ It is very unlikely that involuntary treatments can be described as ‘proper’ because of the lack of consent and undignified mechanisms of administration. Wicks notes that that “the lowest form of prohibited treatment – i.e. that which is degrading – may be of relevance to the imposition of medical treatment without consent.”¹¹⁷⁷ The implication of inhuman and degrading treatment is any treatment, which affects the dignity of the individual rather than their autonomy.¹¹⁷⁸ Degrading treatment interlinks, therefore, with subjecting a person to humiliation or humiliating experience.¹¹⁷⁹ The fundamental aspects of dignity require consent and freedom of choice.¹¹⁸⁰ Ensuring that individuals are not subjected to humiliating experiences does not exclude the relevance of autonomy.¹¹⁸¹ It therefore follows that the autonomy and dignity of an individual will be in jeopardy if their dignity is threatened.¹¹⁸² Cooper further asserts that where ordinarily such unconsented treatment could have led to assault charges, the brief note by the Mental Health Act Commission without express legal clarification further empowered medical practitioners to override the will, choices and bodily goals of the

¹¹⁷⁵ Care Quality Commission, *op. cit.*

¹¹⁷⁶ Terence M. Dovey, Claire V. Farrow, Clarissa I. Martin, Elaine Isherwood and Jason C.G. Halford, ‘When Does Food Refusal Require Professional Intervention?’ available at <http://www.eurekaselect.com/84790/article> [accessed 12th August 2019].

¹¹⁷⁷ Wicks, *op. cit.* pp.21-22.

¹¹⁷⁸ *Ibid.*

¹¹⁷⁹ *Ibid.* p.21.

¹¹⁸⁰ *Ibid.*

¹¹⁸¹ *Ibid.* pp.22-23

¹¹⁸² *Ibid.*

individual.¹¹⁸³ Critics of the right-based approach to treatment fail to consider the natural cycle of the anorexic body when discharged from invasive treatment. It is not farfetched to assume that a person who is not a voluntary patient would not adhere to a system that they did not consented to *ab initio*. Draper rightly points out: “once their weight is stabilized and they are released into out-patient care, many will begin to starve themselves again.”¹¹⁸⁴

The compulsory detention and involuntary feeding of anorexics under the Mental Health Act 1983 will always be contended as incompatible with the provisions of Article 5 of the ECHR. Article 5 clearly stipulates that: “[e]veryone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.”¹¹⁸⁵ Wicks notes this right correlates to external interferences and protecting autonomy. The underlying meaning of Article 5 provided grounds for interpreting protection of physical integrity to include expressing the right to refuse medical treatment.¹¹⁸⁶ It therefore follows that detained mentally ill patients who feel their rights to liberty and security amongst other rights have been violated can therefore institute a claim against a public authority or person who has acted in a way that contravenes Article 5. Anorexic patients whose capacity was not fairly assessed under the Mental Capacity Act 2005 or patients who feel unjustly detained under the Mental Health Act 1983 can bring proceeding under the HRA by relying on “the convention or rights concerned in any legal proceedings but only if he is (or would be) a victim of the unlawful

¹¹⁸³ The Independent, ‘Doctors Get Right to Force-Feed Anorexic Patients’ 5th August 1997 available at <https://www.independent.co.uk/news/doctors-get-right-to-force-feed-anorexic-patients-1244001.html> [accessed 23rd June 2019].

¹¹⁸⁴ Heather Draper, ‘Treating Anorexics without Consent: Some Reservations’ (1998) 24 (1) Journal of Medical Ethics p. 5.

¹¹⁸⁵ ECHR, Article 5.

¹¹⁸⁶ Wicks, *op. cit.*, p.22.

act’’.¹¹⁸⁷ Noteworthy however is that a person’s dependence on a convention right to seek redress cannot be restricted in making claims of his rights to freedom under other laws in the United Kingdom.¹¹⁸⁸ Proceedings to make a claim under the HRA must be submitted to the court or tribunal before the year ends, which starts from the first date the complaint of violation of the patient’s rights occurred.¹¹⁸⁹ The court also has the discretion to allow an application under equitable circumstances after the period stated in section 7(a) has expired.¹¹⁹⁰ It appears there would always be a conflict between respecting the liberty, ideals and best wishes of the anorexic body especially if those wishes do not aid their recovery in anyway. Joana Whiteman explains that the case of *E* in *NHS v E* indicates the “conflict that exist between the respect of the freedom and autonomy of a person to make their own decision on one hand and the perception that there is need to protect the best interest of vulnerable people by preserving lives.”¹¹⁹¹

However, from anorexia nervosa case laws, there is a strong indication that when the courts face such dilemma, they are predisposed to take the side of preserving life.¹¹⁹² This raises questions on how violation claims by mentally ill patients are handled and if those in authority gloss over these claims because of their level of vulnerability. For instance, the delay by the local authority in bringing *E*’s case before the court *ab initio* should have raised a question on whether such curtailment of liberty constituted a violation of *E*’s rights under Article 5 of the ECHR.¹¹⁹³ Involuntary treatment procedures predominantly lack accountability, participation and transparency and are

¹¹⁸⁷ HRA, Article 7 (1)(a)(b).

¹¹⁸⁸ HRA, Article 11 (a).

¹¹⁸⁹ HRA, Article 11 (7)(5)(a).

¹¹⁹⁰ HRA, Article 7(5)(b).

¹¹⁹¹ Whiteman, *op. cit.*, pp.149-153.

¹¹⁹² Welsh, *op. cit.*

¹¹⁹³ *Ibid.*

often challenged on grounds of the legality of the administrative mechanisms as well as the applicable standards of care. Critical questions surrounding involuntary treatments attempt to address what is the right or wrong approach in managing an individual's experience regardless of whether they are in their most powerful or most vulnerable state. Understanding the value of individual choices and recognising the fundamental requirement of rights in the day-to-day practice is maligned within the healthcare sector. The difficulty in integrating human rights in health care becomes more pronounced in situations where the mental capacity and competence of the individual is in question. The current evolving intersection between health care and human rights is because of conflict. The unusual overlap exposes the visible difficulties in finding a satisfactory outcome in resolving reoccurring moral dilemmas connected with medical practice. Prevalent subjects bordering on human rights complaints during medical treatments or care are often not acknowledged and questions on the boundaries and limits remain unanswered.

Keywood is of the opinion that medical practitioners seek court enforcement to legitimize treatment decisions because of the judiciary's enthusiasm to contest decisions made by experts in that field, the public regression in their faith in the medical profession which leads to an increase in medical lawsuits that produce unsatisfactory outcomes for the petitioners.¹¹⁹⁴ Moreso the more recent development in acknowledging the rights of a patient as a significant ideal in legal and ethical concepts.¹¹⁹⁵ However, the English court's input in this critical decision-making has also been plagued with procedural, ethical and legal issues. *Re C (A Minor) (Medical*

¹¹⁹⁴ Keywood, *op. cit.*, pp. 697-707.

¹¹⁹⁵ *Ibid.*

Treatment: Court Jurisdiction)¹¹⁹⁶ was the first case where the question of the jurisdiction of the English courts to enforce involuntary treatments, which affect the liberty and autonomy of the anorexic body, arose. The initial question before the court was to determine if the sanction, detention and use of reasonable force to achieve treatment were lawful in the case of *C*. *C* was a sixteen year-old girl suffering from anorexia nervosa who had an established history of escaping from medical treatment clinics and was detained involuntarily in a specialist clinic. Although *C* requested to voluntarily submit to the treatment without a mandate from the court, the medical director was opposed to this view insisting her detention formed the core part of her treatment. The local authority applied to the court requesting that the courts detain *C* for further treatment pending when the treatment for her illness is completed. The jurisdiction of the English courts to make such order was challenged.¹¹⁹⁷ The grounds of challenge was based on medical practitioners' interference to take critical treatment decisions even though such decisions involved invasive and coercive methods that impede on the patient's freedom, liberty and personal privacy. They are therefore at conflict to make a decision that can either aid physical recovery by preventing any damages arising from the lack of nutrition or just respect the patient's decision to refuse treatment.¹¹⁹⁸

Jerjes, et al understood there is a current difficulty in striking a balance in law, which can reflect the interests of the medical practitioners as well as protect the best interests of the individuals who depend on them.¹¹⁹⁹ The widespread of absolute paternalism and solitary reliance on medical practitioners as the decision makers in treatment

¹¹⁹⁶ *Re C (A Minor) (Medical Treatment) op. cit.*

¹¹⁹⁷ *Re C (A Minor) (Medical Treatment) op. cit.*

¹¹⁹⁸ Silber, *op. cit.* 283-288.

¹¹⁹⁹ *Jerjes et al, op. cit.*

situations has become problematic for individuals who value the expression of their rights even beyond justifiable legal remedies. In many ways, treatment practitioners are seen as performing their duties without knowing the ways to fulfill the human rights mandated by these UK acts and the ECHR. It is unproductive for individuals to rely only on the abstracts of the ECHR's articles to decry unlawfulness or inconsistency without legal precedence before the European Court of Human Rights.¹²⁰⁰ Uvin insists that:

“The risk always exists that taking up a right based approach amounts to a little more than making nice statements of intent regarding that it would be nice to achieve, or duties we would like the world to assume one day, without setting out rights or methods of avoiding the slow and dirty enterprise of politics.”¹²⁰¹

Invasive treatments carried out without the consent of the patient can also be seen as an infringement of Article 8 of the ECHR. Article 8 states that “[e]veryone has the right to respect for his private and family life, his home and his correspondence.”¹²⁰² A public authority therefore cannot override this right except for reason of “national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”¹²⁰³ Article 8 establishes the right to privacy in greater terms which inter-alia covers the broader terms of both physical and social identity

¹²⁰⁰ Code of Practice: Mental Health Act 1983, s. 23 (9).

¹²⁰¹ Uvin, *op. cit.*, p.171.

¹²⁰² HRA, Article 8(1).

¹²⁰³ HRA, Article 8 (2).

including the right to personal autonomy and personal development.¹²⁰⁴ In *Tyraic v Poland*, the courts reinforced that private life includes to certain degree the respect for physical integrity and it becomes the obligation of the state to ensure that this right is secured, enforceable and guaranteed.¹²⁰⁵ There also exists the problem of presumption of the absoluteness of the right to life entrenched in the ECHR which resultantly qualifies for strict adherence. In establishing the right to personal freedom for anorexic patients, a critical analysis of Article 8 of ECHR reaffirms protection of private life against all intrusions into people's lives in a grass root sense of guarding a person's private space, be it their head or their home.¹²⁰⁶ Autonomy is comprehensively advocated for in liberal societies as the right of an individual to self-rule. The concept and ideals of autonomy provides dominant safeguards allowing patients to exercise jurisdiction over their own body; however, the courts on one end do not expressly address what these safeguards are and which ones are specifically available to adult sufferers who lack capacity. Lawrence explains that there is an established link between anorexia nervosa and the response to the crises about their autonomy and independence.¹²⁰⁷ This crisis can occur at any stage of a person's celebration of self-determination¹²⁰⁸ struggle for independence and assertion of the right to make their own decisions. For an anorexic woman, for instance, there is always a paradigm shift from just a desire to stay thin but also a desire to be in control and exert influence on her body. It is the thought of losing that right to self-rule or independence that creates that fear – the fear of gaining weight and an obsession with

¹²⁰⁴ Wicks, *op. cit.*, pp.17-40.

¹²⁰⁵ *Tyraic V Poland*, Application No.1410/03, Judgement delivered March 2007 p. 107. See also *Pretty v UK* 2002 35 EHRR para.61.

¹²⁰⁶ The ECHR reiterates in Article 8 as follows. 1) Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in democratic society in the interest of national security, public safety or economic wellbeing of the country, for the protection of health or morals or for the protection of the rights and freedom of others.

¹²⁰⁷ Marilyn Lawrence, *The Anorexic Experience* (London, Women's Press Handbook 1998). pp.37

¹²⁰⁸ Keywood, *op. cit.*, pp.604.

their body mass index remaining as low as possible. The underlying issue in an anorexic behaviour is exerting control and power over their feeding, appearance and the way their body develops. Therefore, the value of autonomy is very important for an anorexic patient.

Wicks recognises that the essence of individual autonomy is established on their ability to exercise the right to refuse treatment. Consideration is therefore placed on preserving bodily integrity rather than conserving life or health.¹²⁰⁹ Identifying the meaning centred anorexic body as possessing the right to refuse involuntary treatment is a critical step especially with the emerging needs for more inclusion of the values and morals of the individual by reinforcing consent and participation. However, the more poignant question will remain on how refusing involuntary treatment can succeed within a rights-based framework especially with reference to the ECHR.¹²¹⁰ First, there is the recognition that self-determination is at the core of rights protection under the ECHR; however, this interest when applied in refusing involuntary treatment has been weighed against the inviolability of life. Safeguarding the right to stay alive is therefore contrary to other fundamental values, which an individual possesses, especially autonomy in rationalizing an achievable framework for rights-based actions.¹²¹¹

Secondly, the medical treatment administered must be for the mental disorder the patient is suffering. The Mental Health Act 1983 does not give any powers to impose treatment for any physical disorders that are unrelated to the patient's mental

¹²⁰⁹ Wicks, *op. cit.*

¹²¹⁰ *Ibid.*

¹²¹¹ *Ibid.*

disorder.¹²¹² However, the causal link between physical and mental disorder has allowed the courts to utilise this section to declare that some treatments (including reasonable restraint) would be lawful despite the patient's refusal. The justification had been that some physical disorders might be symptomatic of, or may contribute to the severity of, or be the cause of, some mental disorders. Treating the physical disorder is in effect treating the mental disorder. Section 63 has been stretched to include within its scope forced feeding for the treatment of anorexia and the delivery of a baby via a caesarean section. Individuals diagnosed of anorexia nervosa may be detained forcibly for treatment under section 2 and 3 of the Mental Health Act whether they are competent or incompetent. In *Riverside NHS Trust v Fox*, force-feeding was established as a legitimate treatment for anorexia nervosa patients under the act¹²¹³, however Griffiths, et al argue that there is no stipulation forced feeding or nasogastric therapy represents a form of treatment enforceable under the Mental Health Act 1983.¹²¹⁴ The use of forced-feeding as a treatment for the mental disorder is therefore contestable.¹²¹⁵ It is fair to establish that the complexity of this illness places anorexia nervosa sufferers at the lower end of vulnerability, needing greater rights protection under the law.¹²¹⁶

The prominent view in analysing the right of the meaning centred anorexic body to refuse treatment reveals that in fulfilment of the ECHR, the UK laws choose sanctity of life over expressions of individual autonomy.¹²¹⁷ Generally, to force-feed or detain someone when they refuse force-feeding can give rise to both criminal and civil

¹²¹² *Ibid.*

¹²¹³ *Riverside Mental Health Trust v Fox* [1994] 1 F. L. R.

¹²¹⁴ Griffiths, et al *op. cit.*, pp. 127-150.

¹²¹⁵ *Ibid.*, p. 178

¹²¹⁶ Wicks, *op. cit.*, pp.17-40.

¹²¹⁶ *Ibid.*

¹²¹⁷ *Ibid.*

liabilities.¹²¹⁸ It is also a violation of their fundamental rights to privacy, personal autonomy, and personal development entrenched under the ECHR.¹²¹⁹ Diagnosed anorexia nervosa sufferers are involuntarily classified under sections 2 and 3 of the Mental Health Act 1983 for treating their mental disorders.¹²²⁰ Section 63 of the Mental Health Act 1983 removes the requirement of consent prior to treatments.¹²²¹ Article 9 of the ECHR provides for the freedom to manifest one's thoughts and belief. The thoughts and beliefs of the anorexic body form part of their experience, which informs their actions of control, which they are at liberty not to relinquish. Removing consent can therefore imply a denial of their rights to thoughts in expressing their beliefs and values as provided under Article 9.

The static position of the section 63 of the Mental Health Act¹²²² appears discriminatory and adverse to complete fulfilment of Article 14 of the ECHR.¹²²³ Bridgman points out that it is possible to argue that section 63 of the Mental Health Act cannot justify restraint under the law; however at first glance there exists an underlying connection between the physical and mental aspects of this disorder so it therefore seems plausible that the MHA can enforce treatment on physical disorders connected to the treatment of a patient's mental disorder. Bridgman argues that there is no possibility of providing care to patients who resist them without exerting some control over their behaviour in a way that diminishes their liberty. The effect of using these methods of restraint or other invasive treatment methods as part of the treatment

¹²¹⁸ Kluge, *op. cit.*

¹²¹⁹ ECHR, Convention for the Protection of Human Rights and Fundamental Freedom available at http://www.echr.coe.int/Documents/Convention_ENG.pdf [accessed 4th May 2019].

¹²²⁰ Rethink Mental Illness, Mental Health Act 1983 available at <https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/mental-health-act-1983/> [accessed 11th June 2018]

¹²²¹ Mental Health Act 1983.s.63.

¹²²² Mental Health Act 1983. s.63.

¹²²³ Wicks, *op. cit.*

for mental disorders, such as anorexia nervosa, goes way beyond mere justification for using them as the emotional and physical needs of these sufferers are not included in decision-making. The entire medical narrative on involuntary treatment focuses on ensuring full recovery of the person; however, all analysed cases reveal little proof was shown to the effect of a positive outcome that leads to the person willingly consenting to giving up their autonomy in order to achieve full recovery. Invariably, there is no guarantee that force-feeding a severely emaciated individual can lead to full recovery. The right to refuse involuntary treatment is not clearly defined in the ECHR. It is still very evident that “self-determination requires that the individual is able to make a determination about his life”.¹²²⁴ The combination of Articles 3 and 8 of the ECHR are relevant to ensure that should treatment be an option, it is consensual.¹²²⁵ The consideration must be on the “right of a patient to determine what is done to their bodies, rather than in terms of the professional duty of doctors to treat their patients to the best of their ability”.¹²²⁶

¹²²⁴ Wicks, *op. cit.*

¹²²⁵ *Ibid.*

¹²²⁶ *Ibid.*

CHAPTER 8

Conclusion

This thesis has critically examined the interpretation of anorexia nervosa, with the core intention of pioneering an alternative approach to the current stringent medical and psychiatric narrative on self-starvation. Furthermore, this thesis identified and introduced the meaning centred anorexic body which presents a clear demarcation between patient- centred anorexic spectrums therefore addressing the questions on how to ensure that individuals' rights, values, morals and advance decisions takes precedence and the body proper is not undermined in mental health process and practice. In defining lines in mental illness, the meaning centred precision recognised a variation of anorexia nervosa, which then can allow a multidisciplinary interaction and exchange providing a valid basis for a positive outcome in enforcing their human rights.

The aim of this concluding part is to ensure that a cohesive understanding of the entire thesis is established by outlining the key areas and research outcomes of preceding chapters. This conclusion will be presented in three parts; part A dissects the main aspects of the arguments presented in the thesis. Part B reviews the main findings and particularly the medical and legal implication for implementation. The third part (C) provides a conclusion by presenting the lessons and outcomes from the thesis.

PART A - Overview

The involuntary treatment of the anorexic person take place to dispense with their consent or participation and therefore presenting a contentious issue in the fields of health care, medicine, psychiatry, and law.¹²²⁷ Medical, legal and social changes have brought forward deliberations on what treatments are adequate for individuals considered to have a mental disorder and to what extent doctors should withhold unconsented treatments.¹²²⁸ Carney recognises that “anorexia nervosa poses particular challenges for medicine, for ethics and human rights, and for law”.¹²²⁹ The pre-eminence of medical archetypes in analysing and evaluating patterns of eating behaviours has pioneered and sustained stringent and presumptuous narratives in the way individuals who exhibit classic signs of anorexia nervosa are treated. Extreme thinness occasioned by self-starvation remains the foremost inclination in the diagnostic isolation of anorexic individuals. Established anorexic body stereotypes means that extreme physical thinness or emaciation becomes a deciding factor in the overall mental capacity decisions. Understanding that anorexia does not exist in one spectrum neither does extreme physical thinness immediately qualify an individual as incapacitated and unable to function or participate in his or her own decision making, clinicians can then broaden their approach towards granting autonomy and participation. Historically, the best convincing arguments about stereotypical anorexia build on the premise of exclusivity to western patterns, bonded by media culture and exposure to the glitz and glam of westernised thin body obsessions. Essentially, with a systematic stereotypical understanding, clinicians enforce involuntary treatment

¹²²⁷ Rebecca S. Dresser, ‘Legal and Policy Consideration in Treatment of Anorexia Nervosa Patients’ (1984) 3(4) *International Journal of Eating Disorders* pp. 43-51.

¹²²⁸ Irvin, *op. cit.*, p. 858.

¹²²⁹ Carney, *op. cit.*, p.1.

procedure. The empirical work in chapter 4 is extremely critical as it establishes the behavioural patterns of anorexia as a non-western bound syndrome. In establishing the non-Western behavioural patterns, we discover that there are individuals who have exactly the same BMI recognised by the DSM of Mental Disorder, however they have not been subjected to detention, force-feeding or any other involuntary treatment mechanism. Part of the reason for the lack of enforced medical treatment also lies in the absence of mental health laws that recognise the anorexic body as mentally ill and thus subject of treatment.

Western psychiatric discipline is historically manually monotonous in the way standard diagnoses are handled and will seemingly revolt attempts to introduce a post-modern cultural, meaning-centred dimension to a well-labelled and stereotyped disorder. Regardless of western disapproval, accepting a cross-cultural variation within a meaning-centred approach highlights indigenous practices, values, morals, choices, beliefs and views, which extends beyond biological and medical models. With stringent psychiatric dedication to in-depth scientific analysis, research and diagnosis for treating the disorder labelled broadly under mental illness, it becomes almost impossible for other disciplines not to overtly depend on the one dimensional, standardized diagnostic and treatment criteria to resolve every issue arising from the disorder. For example, courts of law have become overtly reliant on the testimonies of doctors and psychiatrists to enforce involuntary treatment decisions that can curtail an individual's rights and freedoms. It therefore follows that when the core standardized diagnostic and treatment criteria are reconsidered, then other disciplines can progressively self-regulate to accommodate nascent approaches.

The field of psychiatry has remained a dominant genre in the diagnosis, treatment and assessment of the anorexic body. It is therefore not surprising that altering the established model of practice to incorporate a cultural meaning centred perspective will involve including cultural viewpoints, generating new meaning and expanding the cultural framework to fit a variation of people. Trying to understand or analyse the meaning behind creating a resistant body may appear tedious but it might appear to be the best approach in resolving dilemmas of best interest, consent, capacity and, to a large extent, human rights. Remarkably, by acknowledging that an individual's ideals, morals and values play a significant part in their conscious experience will also reveal there is an informed amount of competence and capacity to refuse involuntary treatment. Consent in this case will be non-negotiable and will be placed at the centre of all clinical modalities. This is not to say that medical solutions to the secondary outcome of self-starvation (weight loss) cannot be considered; however, that is a later stage that can be furnished only through consent. In cross-cultural systems where the thin body is not ideal, any occurring disease as a result of self-starvation in a meaning-centred anorexic body are unintended, somewhat irrelevant in their experience and often a by-product of their resistance to the normalized body. Hence, it will appear that the disease can only become relevant in their journey if they consent to addressing the disease in a way that does not make them relinquish control or permanently end the meaning centred resistance. This is not to say that a certain aspect of the meaning centered anorexic body may not alter in the process. As expected, a certain amount of control will be relinquished if it is deemed necessary; but in this instance there is a shift focus from what clinicians want to what the individual needs and believes is in her best interest. The problem in generic assessments and diagnosis of disorders are compounded by the manner of approach of

external vessels. The approach of the Mental Capacity Act and the Mental Health Act is to treat the individual as the secondary vessel, rather than the first and therefore assume in some manner that a one-day diagnostic opinion trumps life-long experiences, beliefs and values. The impatience of clinicians to delve into the underlying factors or validate the role culture, beliefs and experience play means that treatment options explored do not account for the best interest of the individual and most often restrict their self-expression

Unfortunately, most treatment professionals do not agree with Griffith's strong convictions that there is no stipulation that force-feeding or nasogastric therapy represents a form of treatment enforceable under the Mental Health Act 1983.¹²³⁰ Potent debates surrounding involuntary treatments focus on the absoluteness of the provisions of the Mental Health Act and the exclusivity of the powers bestowed on treatment professionals to act as they deem fit. The core principle of the Mental Health Act 1983 therefore removed the requirement of consent for individuals typically categorised as suffering from a mental disorder. Clinicians are therefore still adverse to new or further demands for advancing the MCA and the MHA based on the new emerging themes embedded in a rights-based approach. There might be several problems connected to the focus of finding¹²³¹ meaning underlying a self-starvation. First, associating self-starvation with meaningfulness strengthens the autonomous claims of the individual should they decide to refuse involuntary treatment to address the unintended physical deteriorative aspect of the disorder. Second, in setting great emphasis on the meaning of their experience, which informed the ultimate decision to self-starve, will diminish the instituted psycho medical

¹²³⁰ Griffiths *et al*, *op. cit.*, pp. 127–150.

¹²³¹ *Ibid*

position based strictly on medical standard diagnosis and evaluation. There is therefore a shift in the traditional role of the doctor-patient type relationship where the doctor assumes the *alpha and omega* position, handing down treatment and care directives to the individual without considering their rights, choices and values. Lastly, there is diminished misconception, stereotypes and propaganda highlighting the anorexic body's self-suffering in order to enforce involuntary treatment.

A close analysis of anorexia cases reveals the dilemma to preserve the right of autonomy from jeopardy while “applying legal tools to the organic swamp of human pathology.”¹²³² The Court of Protection has in several cases (*Re: E, L, X*)¹²³³ proved to be presumptuous of the lack of capacity of the anorexic body as well as shown to utterly disregard advance decisions for preserving life at all cost. In such situations, treatment professionals and, to a large degree, the courts lack the ability to make a clear distinction that acknowledges the margin between variations of a conceptual non-risk, meaning centred individuals and suicidal patient-centred ones. This identification will enable an adaptation provision of personalised care and management for persons normalised in those tangible patterns of behaviour regardless of the stiff labels required by the Mental Health Act. On the one hand, advocates for involuntary treatments argue strongly to justify dispensing medical treatment without the individual's express consent. Such justification of paternalistic intervention is

¹²³² UK Human Rights Blog. ‘Anorexia, Alcoholism and the Right to Autonomy’ available at <https://ukhumanrightsblog.com/2014/10/22/anorexia-alcoholism-and-the-right-to-autonomy/#more-24678> [accessed 2nd December 2018]

¹²³³ *A Local Authority v E* [2012] EWHC 1639 (COP). *NHS Trust v L* [2012] EWHC 2741 (COP). *NHS Trust v X* [2014] EWCOP 3.

without consideration to the perils of involuntary treatment as a direct violation of personal autonomy, infringement of their rights to make informed choices without being unduly influenced or forced.¹²³⁴ Involuntary or compulsory treatments emphasise the different unorthodox forms of restriction and deprivation of rights and liberty.¹²³⁵ It is imperative that the personal behaviour, actions, and choices of a person be respected regardless of whether that decision is valid, just or detrimental.¹²³⁶ Critics of involuntary treatments argue that respecting individual rights and autonomy, which are central parts of medical law and ethics, should be ranked as the most important.¹²³⁷ The reasoning is because involuntary treatment breeds anti-rights practices, which may infringe on some fundamental rights of an individual.¹²³⁸ Coggon points out the growing tension on what exactly is involved in involuntary psychiatric treatment and where the legitimacy for such interventions derives.¹²³⁹ The conflict of finding a balance becomes evident as treatment professionals attempt to safeguard the lives of the people they deemed dangerous to self and in the same vein ensuring that they are given a certain degree of individual freedom should they decide to self-determine.¹²⁴⁰ The difficulty in reaching a balance is understandable given the complexity of anorexia. More so, careful consideration is given to the ethical quandaries that arise in relation to people with extensive experiences and perspective about the world. The process of inclusion and interaction with the anorexic body, for instance, would entail a degree of established capacity, as well as “self-awareness, the ability for thinking, the willingness to take personal

¹²³⁴ Matusek and Wright, *op. cit.*, p.436.

¹²³⁵ Brunner, *op. cit.*, p. 9.

¹²³⁶ Matusek and Wright, *op. cit.*

¹²³⁷ Lewis, *op. cit.*, p. 23.

¹²³⁸ *Ibid.*

¹²³⁹ John Coggon, ‘Alcohol Dependence and Anorexia Nervosa: Individual Autonomy and the Jurisdiction of the Court of Protection’ (2015) 20(4) Medical Law Review p. 665.

¹²⁴⁰ Dresser, *op. cit.* p. 44.

responsibility, openness to alternative choices, and the ability to monitor and implement feedback subsequent to ethical decision.”¹²⁴¹

Responding to the work of Herbert and Weingarten, Kluge reveals that most anorexics have little or no say in making treatment decisions as they are often involuntarily committed to various invasive procedures which encroach on their dignity, bodily integrity, and autonomy.¹²⁴² Giordano supports Kluge’s argument, insisting that many accounts of anorexia recount episodes of unconsented tube feeding and hospitalisation. There is an overwhelming tale of forceful hospitalisation despite relentless resistance.¹²⁴³ On the other hand, Lawrence contends there is an established intersection between anorexia nervosa and the response to the crisis of autonomy and independence.¹²⁴⁴ This crisis can occur at any stage of a person’s assertion of self-determination, bodily integrity, and right to make her decisions. In many ways, the anorexic body is relentlessly self-normalizing, reflecting an internal, stable management of self, a ‘resistance to the cultural norm,’ regardless of consumer culture illogicality.¹²⁴⁵ For the anorexic woman, denial of their values and choices enhances the body assent as a victim of oppression, enhancing the paradigm shift from just a desire to stay thin but also a willingness to be in control and exert influence on her body.¹²⁴⁶

Human existence, progression and evolution are indicative of choices and decision unconventional to social genre. It is the purest form of existence in a natural state constructed outside the boundaries of bodily slavery. We proceed with the historical

¹²⁴¹ Matusek & Wright, *op. cit.*, p.448.

¹²⁴² Kluge, *op. cit.*

¹²⁴³ Giordano, *op. cit.* p.8.

¹²⁴⁴ *Ibid.*

¹²⁴⁵ Bardo, *op. cit.*, pp. 201-202.

¹²⁴⁶ Marilyn Lawrence, *The Anorexic Mind* (London, Kamac Books 2008).

observations of the struggle to embrace individual actions of freedom, in this instance aware that those choices do not interfere or restrict the freedom of others. Yet, the great negative commandment ‘Thou shalt not allow any man to interfere with the liberty of any other man’ still sits in the abstract corridors of reality.¹²⁴⁷ Amartya Sen bike-riding example equated the ‘state of being’ to the ability to function intentionally and independently.¹²⁴⁸ For Sen, self-fulfillment and expressing real autonomous emotive capabilities is essential to the way a human being lives, acts, be or do.¹²⁴⁹ Those choices can only be valuable if they are autonomous choices with the ideals of equality, justice and freedom. Similarly, Martha Nussbaum acknowledged the correlation between human rights and human capabilities. It is intended to provide an unorthodox method for enjoyment of human rights within a system that can respect the individual differences and preference.¹²⁵⁰ Nussbaum argues that individual functions can only be communicated in its true human form, which entails freedom to exert human powers in self-expressive and creative means. Tangible focus should be placed on the individuality of a person and themes and patterns that they are evolving.¹²⁵¹ Inability to perform such functions that express human individuality freely is inhuman and animalistic and devalues people’s autonomy. A crucial part to fulfilling these central capabilities encompasses the respect for bodily integrity. As Nussbaum points out, bodily integrity is the ability to move around freely, along with total dominance and control over their body.¹²⁵²

PART B – *Findings*

¹²⁴⁷ Huxley, *op. cit.*, p.53.

¹²⁴⁸ Kleist, *op. cit.*

¹²⁴⁹ Sen, *op. cit.*, p.17.

¹²⁵⁰ Nussbaum, *op. cit.*, p.96.

¹²⁵¹ Nussbaum, *op. cit.*, pp.69-72.

¹²⁵² Kleist, *op. cit.*

The Mental health Act 1983 requirement of posing dangers to others as well as oneself has become redundant as self-harm is solely focused on addressing the exact mental state of the individual without due consideration to other crucial behavioural indicators. In addition, clinical analysis of the competency and capacity of the individual to make medical treatment decisions have strict criteria under the Mental Capacity Act 2005. Extreme physical thinness or emaciation and low BMI assume the mantle for mental illness irrespective of the subjective underlying experiences therefore furthering the psychiatric narrative. Chapter 1 of this thesis therefore reveal that at the core of the structural complexity in understanding anorexia, there is a lack of boundary between individuals who have life-threatening anorexia nervosa (suicidal body) and the other spectrums of anorexia.. Although Schreiner agrees that succumbing to self-starvation may be relevant in protecting an individual's sense of self; however such approach is fragile and does not represent the totality of the individual's being.¹²⁵³ Schreiner also points out that changing the body rather than the personality through self-starvation may be counterproductive because of the difficulty to disconnect the body from the psyche. More so, any form of self-starvation exerts a significant strain and pain on the body.¹²⁵⁴ Although Schreiner makes some valid points, the totality of a person's makeup is not arrived through self-starvation rather through a concise composition of their experiences, which historically reflects their values, choices and morals. Self-starvation becomes a decisive and conscious outcome of their expressions rather than the totality of their being. Medical discourse has long thrived on a one-dimensional approach in assessing, diagnosing and treating the anorexic body without understanding the multifactorial nature of the abnormal patterns of eating disorders. The one-dimensional ideology of anorexia expressed

¹²⁵³ Michael Schreiner, 'Anorexia and Neurosis' (2012) available at <https://evolutioncounseling.com/anorexia-and-neurosis/> [accessed 12th April, 2019].

¹²⁵⁴ *Ibid.*

within the language of severe forms of psychotic neurosis, which triggers suicides, depression and borderline personality disorder not related to just their anorexia alone. The outcome of a generalised outlook on all anorexic bodies means that the other spectrums of the anorexic body are unrecognised in the process and are classified within the suicidal bodies seeking their right to die. The individuals that fall within the suicidal anorexic body are then medico-legally generalized and labelled in the same category with the meaning-centred, self-preserved individuals who have enough competence to make decisions around their bodily integrity. The suicidal body is self-purged and rejected, thriving on non-existence and the need to escape however possible from their reality. Individuals who fall into this category are unable to normalize their pattern of behaviour neither can they create a resistant body, which incorporates the effects of their negative or positive experiences. Interpreting their suicidal body presumes worthlessness and their values and belief are disassociated from their reality. Extreme distortion of the existence of experience means that the suicidal body is unable to engage thoroughly the essence of their expertise therefore impossible to produce a subjective view. The meaning underlying their experience is redacted in principle and in reality non-existent. There is therefore logical consideration that they are unable to consciously make informed decisions about their life and therefore may lose the freedom and autonomy to do so. Consent is therefore taken away as they are unable to make competent decisions. Involuntary processes are then necessary and initiated to help normalize, self-contain and regulate their conduct and behaviour.

The respondents to the questionnaire in this thesis reside within the communities where being fat is considered a value and virtue and taunted as the ultimate sign of beauty

compared to the western notion of the thin body ideal. The ideal of beauty also extends beyond just attracting the opposite sex but seen as enhancing the prospect of child bearing and a good family life. Existing within a society that characterises the fat woman as beautiful presents the perfect environment to investigate why some women become non-conformist and resort to self-starvation or the anorexic body devoid of media influence. In this setting, the anorexic body thrives and self-starvation comes meaningful to actualising autonomy and resistance to engraved patriarchy. As revealed in non-western patterns, the motivating factors for assuming the anorexic body (extremely thin body) is not automatically placed on the presence of mental disorder rather there is an opportunity to investigate further on the reasoning underlining their values and choices. It could be a way of ascertaining her cultural right, or cultural identity. We therefore wonder if the mental health laws in the UK presents a disadvantage to the self-starving bodies. In reviewing anorexia case laws, it became apparent that all the involuntarily treated individuals are not isolated incidence of only self-starvation but have other advanced medical issues unrelated to their eating disorder. In *X v NHS Trust*, it was noted that X was an alcoholic who had developed other chronic issue due to her excessive drinking. The judge also recognised that X's excessive alcohol consumption will lead to mortality and increase the likelihood of her demise. This is comparative to the non-western self-starving patterns where there were no other active competing factors to be treated. The assessment of the behavioural pattern of these individuals present a more realisable setting to authentically evaluate the impact of self-starvation.

The distinctive feature of the meaning centred anorexic body is embedded within the cultural contexts of meaning, morals, and experience but also in the cognitive

acknowledgment that there is no desire to starve to death or commit suicide as established in *NHS Trust v X*. It is impossible to deny that a particular demographic of anorexics are not only preoccupied with the mere physical aesthetics of thinness and physical emaciation, which excludes cultural ideals (*Re E*).¹²⁵⁵ The non-meaning centred anorexic body engages in food refusal, self-starvation and body weight management with no clear precise meaning or concept to their self-starvation. The meaning centred anorexic body is subjectively dissimilar; their standard pattern addresses an individualized norm, symbolic to self, culture, morals and experience.¹²⁵⁶ It is evident that the meaning centred anorexic body can lead a conceptually normal life within a controlled weight devoid of any attempt to end their life. All aspects reveal distinguishable traits from other biological and behavioural aspects of non-meaning centred anorexics hence the author's disagreement with Crisp's insistence that all anorexic bodies possess diminished rights of independence and exhibit immaturity in leading a normalized life.¹²⁵⁷ In hindsight, meaning centred anorexic body identifies across cultural borders of allowing a certain degree of autonomy and flexibility in subjective expression of behavioural patterns.

The defining pathway of a person's life is not developed abruptly neither are instincts pivotal or definitive, rather there is a strong connection between how the personal choices of a person is made and how that pathway is navigated to attain their true self.¹²⁵⁸ In the span of an individual's life, various versions are created as they navigate the intricacies of life. The behavioural version that the individual stays with

¹²⁵⁵ *Re E (Medical Treatment Anorexia) op. cit.*

¹²⁵⁶ Banks, *op.cit.* pp.867-884

¹²⁵⁷ Crisp, *op. cit.*

¹²⁵⁸ David Kissane, 'The Rediscovery of the Human: Basic Texts of Viktor E. Frankl' (2007) 5(1) Palliative and Supportive Care pp.77-78.

the individual embodies all the elements of their story and a reflection of their voice chosen with free will, without coercion. The pathway to achieving a definite moment of self-determination is a historic build-up of years of internalization of the effects and impact of social cultural factors. However, to a greater extent, modern day laws, rules and regulation seem to play a significant part and accounts for the modification of behaviours and socio-cultural patterns. The reality ignored by clinicians that there are consequences of repressing the freedom of an individual to self-express, especially by denying free will and personal choices at any stage of decision-making.

The way we view the body is also crucial in the discourse of decision making in medical interventions. Every individualised history of anorexics reveals a trend in the way their actions are guided by the multitudes of experiences from childhood to adulthood. Those experiences are not solitary but constitute a pattern that begets their values, choices wishes and moral. Clinicians and courts of law cannot therefore have a comprehensive and index knowledge of an anorexic without the formalities of the constitute experience. Study across the field for an average anorexic reveals the same base line patterns and trigger in abnormal eating behaviour. First, their experiences were not intra nuclear but controlled by third parties. Childhood experiences marked by oppression, violence or deprivation emanated from factors beyond their control. The anorexic body became the object of this impression whether negative or positive yet they are denied the right make decisions regarding their bodies. Given the way human body exists and functions, the body can be likened to a sponge taking in all the essence of the individual, the footprint of tragedies, triumphs, pain and happiness, needs and wants, etc. The manifest creation of the individual is a self-contained and regulated, self-suffering, preserved and autonomous body. The self-contained and

controlled body is balanced and normalised, adhering to societal expectations and existing within the social, legal and psychiatric boundaries. This body fits into the stereotype and labelling of the medico-legal system. The self-contained and regulated body is a passive, unimpressed and suppressed entity within the strict confines of the Mental Health Act. Understanding their values, choices and the decision is unimportant to the care and management of their behavioural outcomes. Values within the self-contained and organised body are based on pre-established ethics and conventions and not by independent decisions. Individuals within this category are however aware of the negatives and positives of their experiences but do not find the perfect balance that reflects those values. Experiences, therefore, do not form part of their meaning and values are regarded as a crafted construct of the present, which does not correlate with the past or the future. In contrast, the self-suffering, preserved and autonomous body is self-piloted, an individualised creation reflecting their values, choices, belief and conscious present and advanced decisions. There is an awareness of experiences and the meaning underlying the nature of that body, a tribute body that embodies the totality of their being. The self-suffering, preserved and autonomous body is aware of their reality, both the past, present and the future. Making autonomous choices, self-determination and protecting their bodily integrity and autonomy preserve values. The body is accepted and becomes a sanctuary that embodies all those experiences, an individualized creation perfected and presented to the outside world. This body is meaning-centred in reality, elaborate to make a statement and conscious enough to create boundaries against involuntary interference.

PART C - Conclusion and Recommendation

A recent study at Kings College London focused on finding the reason there is a high rate of unsuccessful outcomes in treating anorexia nervosa analysed the DNA of 17,000 people with anorexia nervosa.¹²⁵⁹ Scientists who led the study recommended finding new and alternative approaches, which recognised that anorexia was not solely a psychiatric illness.¹²⁶⁰ It has, therefore, become critical that other contributing factors and multifactorial evidence are accounted for whilst engaging with self-starvation.¹²⁶¹ The question is, why should doctors who are perfectly content with the established medical pathway incorporate or exclusively apply the alternative meaning-centered approach, underscoring cross-cultural experiences and respecting autonomous choices? This question can be analyzed in multiple dimensions; however, the first point to note is that the traditional system has revealed a broken clinician-patient relationship. The first issue might be the implication of using the words “mentally ill patient” (enhancing medical labelling) to address a cross section of individuals who do not want to be relegated or pigeon holed as sick, helpless and in need of a saviour-doctor. The legality and rightfulness of imposing treatments and medical labelling are still disputed by other disciplines.¹²⁶² The challenge and possible solution rests in applying an interdisciplinary approach, especially utilizing “overarching theories which reconcile the conflict or minimize the challenges”.¹²⁶³ The behavioural nature of anorexia is constantly changing, evolving and adapting as their experiences are altered or modified. The response of the anorexic body is therefore redefined by those changes and so is the underlying meaning, which

¹²⁵⁹ Guardian. ‘Anorexia not Just a Psychiatric Problem Scientists Find’ Available Guardian. ‘Anorexia not Just a Psychiatric Problem Scientists Find’ available at https://www.theguardian.com/science/2019/jul/15/anorexia-not-just-a-psychiatric-problem-scientists-find?CMP=fb_gu&utm_medium=Social&utm_source=Facebook#Echobox=1563220022 [accessed 12th April 2019]

¹²⁶⁰ *Ibid.*

¹²⁶¹ *Ibid.*

¹²⁶² Carney, *op. cit.*, p.2.

¹²⁶³ *Ibid.*, p.3.

accompanies the basis for their self-starvation. Regardless of how constant the anorexic body alters or transforms, the medical-legal pathway remains the same with no variation applied to equal their current state. The inconsistency is intensified by the ultimate position of the law, confirming and approving involuntary treatments¹²⁶⁴ based solely on medical diagnostic without due consideration of the multi-dimensional aspects of anorexia.

Statutory provisions which establishes the legality of advanced decision making is not provided for under the current Mental Health Act 1983 especially with regards to statements which are written while the individual still possess capacity, such statutory provisions should also present clarity on the instances of refusals. Owen G. S et al notes that the introduction of advanced decision making into the MHA would “enable and promote the development and realisation of advanced decision making as a form of self-determination thereby removing ambiguity to enhance transparency in a complex and complicated area.”¹²⁶⁵ There are minimal levels of adaptation of advanced decision-making in both the MHA and MCA however a crucial difference in physical and mental healthcare has to be established in order to reflect the balance in policy and principle.¹²⁶⁶ Expressions of autonomy or autonomous actions is often in relation to self expression of the body hence the consideration of the rights to refuse treatment presented by the medical practitioners under medical law is intertwined into the fiduciary relationship that exists within.¹²⁶⁷ Article 5 of the ECHR also lauded the exclusion of the right to refuse medical treatment. Deprivation of liberty can occur

¹²⁶⁴ Carney, *op. cit.*, p. 1.

¹²⁶⁵ Gareth S. Owen, Tania L. Gergel, Lucy .A. Stephenson, O. Hussain, Larry Rifkin & Alexander Ruck Keene, ‘Advanced Decision-Making in Mental Health- Suggestions for Legal Reform in England and Wales’ (2019) 64 International Journal of Law and Psychiatry. pp.162-172.

¹²⁶⁶ *Ibid.*

¹²⁶⁷ *Ibid.*

within the perimeters of the procedures stipulated by law –sound mind and capacity to consent has emerged as fallen within the perimeters of exclusion.¹²⁶⁸ The findings also reveal that need to rethink of how autonomy is applied in healthcare especially in addressing permanent misconceptions in medical law that anorexic bodies exists in perpetual state of incapacity therefore unable to exercise the right to refuse medical treatment. In addition to clarity what exactly constitutes unsound mind, there is also need to “determine which consent and refusals were owed legal respects....and which are not”¹²⁶⁹ A step further is providing a legal identity for the anorexic body with decision making capacity at the time of advanced decision making which ultimately can be upheld under the MHA.

This thesis has shown that the meaning-centred approach to the studies of anorexia removes the rigid clinical approach and interpretation of thinness and self-starvation and amplifies their experiences reflected in their values, choices and decisions. The meaning centred anorexic body exists within the parameters of expressions of autonomy and self-determination. There is still an identity attached to the individual’s experience and a greater understanding of these interactions as vital for progress and acceptance of their identity.¹²⁷⁰ Metseagharun recognised that everything revolves around finding meaning and it will be futile to argue otherwise. Individual experiences are part of the consciousness and in every shape and form defines their reality. Every single moment, emotions, natural impulses (significant or otherwise) leave traces embedded in human DNA. This is unsurprising as the body an individual identifies with and creates is also the body subjected to the control especially within

¹²⁶⁸ *Ibid*

¹²⁶⁹ *Ibid*

¹²⁷⁰ Stefan E. Schulenberg, Lindsay W. Schnetzer, Michael R. Winters, and Robert R. Hutzell, ‘Meaning-Centered Couples Therapy: Logotherapy and Intimate Relationships’ (2009) 40(2) *Journal of Contemporary Psychotherapy* pp.100-102.

repressive cultures where the body is objectified. Normative conceptions present various stages and signs that engage the values and choices the anorexic is accountable to which most times are opposed to clinical and societal standards. Making a meaning-centred identification enables an adaptation provision of personalized care and management for persons normalized in those tangible patterns of behaviour regardless of the stiff labels imposed by the Mental Health Act. Impressions across cultures continue to change and advance the experiences of the individual¹²⁷¹ until the significance of meaning is actualized. Considering a broader basis or meaning-centered approach, reoccurring themes across genres focus on the prominence of the individual as the author and controller of their experiences – actions, choices and value. To create meaning, historical situations are taken into consideration to determine within which framework individual meanings emerge.¹²⁷² The individual controls the narrative and therefore can consciously assume the responsibility – assigning meaning and embracing the outcome. It is not difficult to find that in placing central emphasis on the individual’s choice to self-starve, for instance, there is recognition of their autonomous rights, bodily integrity and inherent dignity – affirmed through a human rights-based approach. Although certain limitations to individual freedom apply when the competence is actively contested or in question, it is almost impossible not to echo the same sentiments as Silber, who insists that autonomy and freedom of choice should trump any other considerations.¹²⁷³ The underlying issue in anorexic behaviour is exercising control and dominance over the way the body is nurtured and developed.¹²⁷⁴ The values of

¹²⁷¹ Temi Metseagharun, “‘A Meaning-Centered Approach’ to Patient Consultation is the same as Spirituality and Psychiatry” (2010) 34(9) *The Psychiatrist* pp. 400-401.

¹²⁷² Paaige K. Turner and Robert L. Krizek, ‘Meaning-Centered Approach to Customer Satisfaction’ (2006) 20(2) *Communication Quarterly* pp.115-117.

¹²⁷³ Silber, *op. cit.*, pp. 284–285.

¹²⁷⁴ *Ibid.*

autonomy, ideals of consent, and inherent dignity are, therefore, very critical to the anorexic body and are also potent attributes in rights protection.¹²⁷⁵ The rationalisation behind embracing the ideals of consent validates the long-standing legal rule of conduct specifying the absolute requirement of procuring the informed consent of a person before any medical treatment.¹²⁷⁶ Understandably, Kirby notably viewed informed consent as a ‘competing principle that reminds us of the privacy of human autonomy’.¹²⁷⁷

¹²⁷⁵ Bernadette Rainey, Elizabeth Wick, and Clare Ovey, *The European Convention on Human Rights* (New York, Oxford University Press 2014) pp. 2–6.

¹²⁷⁶ M.D. Kirby, ‘Informed Consent: What Does it Mean?’ (1983) 9(2) *Journal of Medical Ethics* p. 69.

¹²⁷⁷ *Ibid.*

APPENDIX A

QUESTIONNAIRE

Dear respondent,

Please complete this questionnaire honestly and independently. It is for research. Your answer is the best. Do not write your name. Your responses will be treated confidentially.

Section A:

Supply the following information about yourself.

- I. Institution:.....
- II. Sex:.....Age: Below 18yrs..... Above 18years:.....
- III. BMI.....
- IV. Body size: Very Thin:.....Extremely Thin Bodies:..... Plump:.....

Section B: Extremely Thin Body Association with Mental Illness

Tick "yes" or "No" to each of these statements:

Statement	Yes	No
1. Do you associate your extremely thin body with mental illness?		
2. Do you associate your self-starvation to mental illness?		
3. Are you able to function well (work, carry on everyday life) while assuming this extremely thin body?		
4. Do you believe this is a form of exercising your freedom or autonomous right?		
5. Do you exercise regularly to retain this slim body?		
6. Do you associate the expression of freedom to preserve your bodily integrity with mental illness?		
7. Are you conscious or aware of your choice to become thin?		
8. Are you conscious or aware of your choice to remain thin?		
9. Have you been involuntarily treated?		
10. Do your friends laugh at you because of your thin body?		
11. Does any of your family members consider you ill?		

SECTION C: Extent of Contentment

Tick "Yes" or "No" to each of these statements:

12. Has anyone advised you to go for medical treatment because of your thin body?		
13. If possible, would you like to become thinner?		
14. If you are advised by a clinician, would you change your body size?		
15. Are there occasions you regret the anorexic body?		
16. Would you change your extremely thin body to a normalized body in the future?		
17. Would you advise your plump friends to become extremely thin within meaning?		
18. Do you feel any physical weakness as a result of being extremely thin?		
19. Do you ever feel the urge to cover up part of your body out of embarrassment?		

SECTION D: Reasons for Assuming Anorexic Body

Tick "Yes" or "No" against each of these statements for what describes the reason for your choice to assume the slim body.

	Yes	No
20. Take control of my body		
21. Resistance against cultural oppressive regime		
22. Expression of freedom (autonomy) over my body		
23. Mental illness		
24. Previous experience of a non-thin body		
25. Experience of others with non-thin body		
26. I have been involuntarily treated because of my extremely slim body		
27. The Nigerian environment provides the freedom to express autonomous right without the stereotype of mental illness		
28. The Nigeria environment provides the freedom for control over my body without the stigma of mental illness		
29. To resist the cultural ideal beauty (regarding plump body as a sign of beauty)		
30. To be admired more by the opposite sex		
31. Physiological/medical ground		
32. Because being extremely thin is not a mental illness		

APPENDIX B

Birkbeck University of London,
Malek Street,
Bloomsbury,
London, WC1E
8th May, 2018.

.....
.....
.....
.....

Sir/Ma,

AUTHORIZATION TO COLLECT DATA FOR RESEARCH

I wish to request permission to collect data from your female students for my research. The research is on anorexic body and reason for that feature. The information collected will be restricted to the study and will remain confidential.

Please, I need a written acceptance to assure my university that I actually collected the data from your institution.

Thanks for your anticipated cooperation.

Yours faithfully,

Chisom, Cynthia U.

Glossary

Anorexia Nervosa

An illness often resulting in dangerous weight loss, in which a person, usually a girl or woman, refuses to eat enough over a long period of time.

Autonomy

The ability to make decisions and choices without being controlled by anyone else.

Autonomous

The ability to have the freedom to act independently.

Bulimia Nervosa

Bulimia is an eating disorder characterised by a cycle of binge eating and compensatory behaviors such as self-induced vomiting designed to undo or compensate for effects of binge eating.

Bioethics

The ethics of medical and biological research. It is study of the ethical issues emerging from advances in biology and medicine.

Biosocial

The interaction of biological and social factors.

Behavioural

Involving, relating to, or emphasizing behaviour.

Bradycardia

An abnormally slow heart action.

Diagnosis

The identification of the nature of an illness or other problem by examination of symptoms.

Disorder

An illness of the mind or body.

Glucagon

A protein hormone that is produced especially by the islets of Langerhans and that promotes an increase in the sugar content of the blood by increasing the rate of glycogen breakdown in the liver.

Hypothalamus

A region of the forebrain below the thalamus which coordinates both the autonomic nervous system and the activity of the pituitary, controlling body temperature, thirst, hunger, and other homeostatic systems, and involved in sleep and emotional activity.

Hypothermia

The condition of having an abnormally (typically dangerously) low body temperature.

Malnutrition

The lack of proper nutrition, caused by not eating enough of the right things, or when the individuals diet doesn't contain the right amount of nutrients.

Meaning Centred Study

A way of understanding and uncovering meaning by focusing on the individualised reasons underlying the experience.

Menstruation

The process in a woman of discharging blood and other material from the lining of the uterus at intervals of about one lunar month from puberty until the menopause, except during pregnancy.

Misogyny

The dislike of, contempt for, or ingrained prejudice against women.

Morality

The principles concerning the distinction between right and wrong or good and bad behaviour.

Nasogastric Tube

A tube inserted through the nose down the throat and esophagus, and into the stomach. It can be used to give drugs, liquids, and liquid food, or used to remove substances from stomach.

Patient Centred Approach

A biomedical modelled relationship which focuses on the individual as solely accountable to the doctors who make sole decisions regarding treatment and treatment and treatment outcomes.

Periventricular Nucleus

An autonomic control centres in the brain, with neurons playing essential roles in controlling stress, metabolism, growth, reproduction, immune, and other more traditional autonomic functions.

Prognosis

An opinion, based on medical experience, of the likely course of a medical condition.

Stereotype

A widely held but fixed and oversimplified image or idea of a particular type of person or thing.

Slouching

The action or fact of standing, moving, or sitting in a lazy, drooping way or position.

Self Determination

The process a person controls their own life and expresses their choice without external compulsion.

Tour de force

An achievement or performance that shows great skill and attracts admiration.

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